REQUEST FOR PROPOSALS
NO. 09-002

PROPOSALS TO FURNISH

INSURED HEALTH BENEFITS PLANS FOR ACTIVE EMPLOYEES AND RETIREES

Issued by
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, Hawaii 96813

State of Hawaii
May 2009

NOTICE TO OFFERORS

The Hawaii Employer-Union Health Benefits Trust Fund ("EUTF") seeks qualified offerors to furnish Insured Health Benefits Plans for Active Employees and Retirees.

Sealed proposals for this project, RFP No. 09-002, will be received at:

Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, Hawaii 96813

Proposals will be accepted up to 4:00 p.m., Hawaii Standard Time ("HST"), June 29, 2009. Proposals received after this time will not be accepted. The Request for Proposals ("RFP") may be examined at or obtained from the office listed above. The RFP is also available online at www.spo.hawaii.gov in Acrobat Reader format and at www.eutf.hawaii.gov in native file formats, Microsoft Word and Acrobat Reader, as applicable.

For further information, call James Williams, Procurement Officer, at (808) 587-5434.

LEGAL AD DATE: May 27, 2009

TABLE OF CONTENTS

ADMINISTRATIVE OVERVIEW

I. Background

This Request for Proposals ("RFP") is issued by the Hawaii Employer-Union Health Benefits Trust Fund ("EUTF"), an agency of the State of Hawaii ("State"). The EUTF was established by Act 88, 2001 Session Laws of Hawaii. Act 88 is partially codified as Chapter 87A, Hawaii Revised Statutes ("HRS"). Under HRS Chapter 87A, the EUTF is authorized to design, provide, and administer health and other benefit plans for State and county employees, retirees, and their dependents (aka "employee-beneficiaries and dependent-beneficiaries). The benefit plans include medical, prescription drug, vision, dental, and life insurance. The EUTF currently provides benefit plans to approximately 180,000 employee-beneficiaries and dependent-beneficiaries. The EUTF's plan and fiscal year is July 1 through June 30.

The EUTF is administered by a board of ten trustees ("Board") who are appointed by the Governor. Five trustees represent the employee-beneficiaries, one of whom represents retirees. These five trustees are selected by the Governor from a list of candidates provided by the exclusive employee representative organizations. The remaining five trustees, also appointed by the Governor, represent the public employers. The Board's responsibilities include, among other things, determining the nature and scope of benefit plans, entering into contracts to provide such plans, administering the trust fund used to provide such plans and to pay for EUTF administrative expenses, and overseeing all EUTF activities. In several of these activities, the Board is assisted by a benefits plan consultant ("Consultant").

The EUTF's day-to-day operations are administered by an administrator appointed by the Board ("Administrator"). The Administrator is assisted in managing the EUTF by an assistant administrator, a financial management officer, and an information systems analyst. EUTF staff has a total of 24 permanent and 4 temporary employees (including management staff and the Administrator). The EUTF is organized under three branches; Financial Services Branch, Information Systems Branch, and Member Services Branch. A health benefits program manager oversees the Member Services Branch and is supported by employees assigned to customer service duties to answer phones and e-mails from members and to handle all processing for retirees and process all active employee enrollment submissions. The financial management officer oversees the Financial Services Branch and is supported by accountants and account clerks who reconcile employee accounts, collect employer/employee contribution for health benefits and process all payments. The EUTF information system analyst is supported by one IT specialist and provides internal IT support services, HIPAA security responsibilities, and coordinates additional support services provided by Department of Accounting and General Services / Information and Communication Services Division.

The EUTF currently offers the following plans on a self-funded basis: PPO Medical Plan, HMO Medical Plan, High Deductible Health Plan (HDHP), Supplemental Medical Plan, and Prescription Drug Plan. The EUTF benefit consultant (Aon Consulting) presented the Board with calculated rate increases necessary to adequately fund these self-funded plans of 29.4% (active employees) and 17.5 % (retirees). The

Board of Trustees desires to determine whether if would be financially advantageous to convert some or all of its self-funded medical plans to fully insured plans. The Board currently is evaluating the performance of the self-funded prescription drug plan and may consider seeking proposals for a fully insured prescription drug plan at a later date. The Board will consider mid-year implementation of fully insured medical plans if it would be advantageous to the EUTF to do so.

The EUTF FY 2007-2008 Annual Report is included as Appendix A of this RFP. EUTF Annual Reports are available on-line at www.hawaii.gov/budget/LegReports/.

The most recent audited financial statements of the EUTF are attached in Appendix B.

II. Purpose

The EUTF is soliciting proposals from qualified insurers to provide insured medical benefit plans for active employees and/or retirees effective upon award of the contract. Contract(s) awarded pursuant to this RFP may be implemented immediately to replace current EUTF self funded medical benefit plans. A more detailed description of these services is set forth in Paragraph V of the Scope of Work section. When responding to this RFP, we encourage you to describe the ways in which you believe your organization's service capability is unique or would add particular value. Please be succinct in your answers and, if certain services cannot be provided, please so state where appropriate.

III. Authority

This RFP is issued under the provisions of Chapter 103D, HRS, the applicable provisions of the Hawaii Administrative Rules ("HAR") implementing Chapter 103D, HRS, and Chapter 87A, HRS. All prospective offerors are charged with presumptive knowledge of all requirements of the cited authorities. Chapter 103D, HRS, and the HAR implementing Chapter 103D, HRS, are available on the State of Hawaii website at www.spo.hawaii.gov . Chapter 87A, HRS (Appendix K), and the administrative rules of the EUTF (Appendix L) are available on the EUTF website at www.eutf.hawaii.gov .

IV. Procurement Officer and Contract Administrator

This RFP is issued by the EUTF. The individual listed below is the Procurement Officer and Contract Administrator for this procurement.

Mr. Jim Williams, Administrator
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, HI 96813
Phone: (808) 587-5434
Fax: (808) 586-2320
E-mail: eutfadmin@hawaii.gov

V. Procurement Timetable

Listed below are the important actions and corresponding final dates by which the actions must be taken or completed. **Offerors are notified that these dates are estimated by the EUTF and are subject to change at the discretion of EUTF. The EUTF reserves the right to change any date(s) as deemed necessary and in the best interest of the EUTF.** If the EUTF decides to change a date for any reason, notification will be given via the addendum process described in Paragraph XII of this section.

Actions	Date
Release of the RFP	May 27, 2009
Last date for questions	June 3, 2009
EUTF response to questions	June 12, 2009
Deadline to submit proposals	June 29, 2009 4:00 p.m. (HST)
Determination of priority-listed offerors (if any)	July 17, 2009
Presentations by priority-listed offerors (if any)	July 27 - 29, 2009
Best and final offers (if needed)	August 17, 2009
Contractor Selection and Award	August 26, 2009
Contract Start Date	October 1, 2009

Priority-listed offerors selected in accordance with Paragraph V of the Proposal Evaluation section of this RFP may be required to make a presentation during the period of July 27 – 29, 2009 in Honolulu, Hawaii. Priority-listed offerors will be contacted by the EUTF staff to arrange a specific time and location for the presentation, if requested.

VI. Communications with the EUTF; Questions

Offerors and potential offerors (including agents of offerors or potential offerors) should not contact any member of the EUTF Board or any member of the EUTF staff. An exception to this rule applies to firms who currently do business with the EUTF; provided that any contact made by any such firm should be related to that business, and should not relate to this RFP.

If additional information is required regarding this RFP, requests for such information must be submitted in writing (fax and email are acceptable) to the Procurement Officer. The Procurement Officer, listed in Paragraph IV of this section, is the sole point of contact from the date of release of this RFP until the selection of the offeror or offerors to whom a contract will be awarded.

Questions submitted by **4:00 p.m. (Hawaii Standard Time) June 3, 2009** will receive a response from the EUTF by June 12, 2009. Questions submitted after the deadline may receive a response at the discretion of the EUTF. A written response to any questions will be provided by the EUTF via the addendum process described in Paragraph XII of this section.

VII. Submission of Proposals

Offerors must carefully examine this RFP, all amendments via the addendum process (if any), all required contract forms, and other documents, laws and rules, as necessary, before submitting a proposal. The submission of a proposal shall be considered to be a warranty and representation that the offeror has made a careful examination and understands the work and the requirements of this RFP.

Each qualified offeror may submit only one (1) proposal. Alternate proposals will not be accepted.

The proposal should be labeled "Hawaii Employer-Union Health Benefits Trust Fund Health Insurance Benefit Plans RFP 09-002." A master (so marked), twenty (20) copies (one copy must be unbound and ready to photocopy), and one (1) electronic copy (MS Word or Adobe Acrobat format on a 650MB/74 minute format CD) of the response must be received no later than **4:00 p.m. (Hawaii Standard Time) June 29, 2009**. The sealed package should be addressed to the Procurement Officer listed in Paragraph IV of this section.

The outside cover of the package containing the proposal shall be marked as indicated below:

Hawaii Employer-Union Health Benefits Trust Fund
Health Insurance Benefit Plans Proposal
RFP 09-002
(Name of Offeror)

No faxed or e-mailed proposals will be considered or accepted!

VIII. Receipt, Opening and Recording of Proposals

Proposals and modifications will be time-stamped upon receipt and held in a secure place by the Procurement Officer until the established due date.

Proposals may be modified or withdrawn, prior to the deadline for submission of proposals, by the following:

- Modifications - a written notice accompanying the actual modification received by the Procurement Officer; or a written notice accompanying the actual modification by facsimile machine sent to the Procurement Officer, provided that the offeror submits the written notice accompanying the actual modification within two working days of the Procurement Officer's receipt of the facsimile.

- Withdrawal - a written notice received by the Procurement Officer; or a notice by facsimile machine sent to the Procurement Officer.

Proposals will not be opened publicly, but will be opened in the presence of two or more procurement officials. Proposals and modifications will be shown only to personnel having a legitimate interest in them.

After the date established for receipt of proposals, a register of proposals will be prepared which will include the name of each offeror and the number of modifications received, if any. The register of proposals shall be open to public inspection only after a contract has been awarded.

An offeror may withdraw and resubmit a proposal prior to the final submission date. No withdrawals or re-submissions will be allowed after the final submission date.

IX. Best and Final Offer

Best and final offers may be requested by the Evaluation Committee. The Evaluation Committee will provide guidance and additional instructions at the time best and final offers are requested. Any best and final offers must be received by the Procurement Officer at the time and date specified in the Procurement Timetable. If best and final offers are not requested by the Evaluation Committee, of if requested, and it is not submitted by an offeror, the offeror's previous submittal will be construed as the offeror's best and final offer. After best and final offers are received, final evaluations will be conducted for an award.

X. Costs for Proposal Preparation

Expenses for the development and submission of proposals and other responses to the RFP are the sole responsibility of the organization submitting the proposal or other response. Travel and expenses to and from the State of Hawaii are also the sole responsibility of the organization submitting a proposal or otherwise responding to this RFP.

XI. Disqualification of Proposals

The EUTF reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the scope of work. Any proposal offering any other set of terms and conditions, or terms and conditions contradictory to those included in this RFP, may be disqualified without further notice.

An offeror may be disqualified and a proposal rejected for any one or more of the following non-exclusive reasons:

- Proof of collusion among offerors, in which case all proposals and offerors involved in the collusive action will be rejected.
- The offeror's lack of responsibility and cooperation as shown by past work.
- The proposal shows any noncompliance with applicable law.
- The proposal is conditional, incomplete, or irregular in such a way as to make the proposal incomplete, indefinite, or ambiguous as to its meaning.

- The proposal has any provision reserving the right to accept or reject award, or to enter into an agreement pursuant to an award, or provisions contrary to those required in the solicitation.
- The delivery of the proposal after the deadline specified in the timetable.
- The offeror being in arrears on existing contracts with the State or having defaulted on previous contracts.
- The offeror's lack of sufficient experience to perform the work contemplated.
- The offeror's conflicts of interest or lack of independence in judgment.

XII. RFP Amendments and Addendum

The EUTF may modify any part of the RFP, prior to the date fixed for award of the contract, by issuance of an addendum. The EUTF will respond to questions and inquiries via the addendum process. Addenda will be numbered consecutively.

XIII. Cancellation of Request for Proposals/Rejections of Proposals

This RFP may be cancelled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the EUTF or for any other reason permitted by Chapter 103D, HRS, and its implementing HAR.

XIV. Uncertainties Beyond the Control of the EUTF

The EUTF recognizes that circumstances beyond the control of the EUTF may arise that may significantly affect the ability of the contractor to provide the services described in this RFP or as proposed by the contractor. Accordingly, the EUTF reserves the right to modify any contract resulting from this RFP to address such circumstances.

XV. Proposal Bonds; Performance and/or Payment Bonds

No bid bond is required to be submitted with the proposal, and no performance or payment bond will be required for the contract awarded pursuant to this RFP.

XVI. Acceptance of Proposal and Execution of Contract

Acceptance of a proposal, if any, will be made as provided in the Procurement Timetable. The offeror must have the ability to perform as called for in the RFP and in the contract. The EUTF shall be the sole judge of capability. The successful offeror will be notified by letter that its proposal has been accepted and that the offeror is being awarded the contract.

The EUTF reserves the right to award a contract based upon the written responses received and without prior discussion or negotiations.

Appendix C is the contract form that will be used by the EUTF for any contract resulting from this RFP. In submitting a proposal, the offeror will be deemed to have agreed to each provision set forth in Appendix C (including the General Conditions) unless the offeror specifically identifies the provision to which objection is made and submits alternative language. The EUTF reserves the right to further negotiate the terms and

conditions of the contract with the successful offeror; provided, however, that the EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Appendix C. In addition to the terms and conditions set forth in Appendix C, the contract awarded pursuant to this RFP shall consist of the RFP and any amendments thereto, and any additional specific terms and conditions of the contract negotiated between the EUTF and the successful offeror.

The EUTF shall forward a contract to the successful offeror for execution. The contract shall be signed by the successful offeror and returned within ten days after receipt by the offeror or within such further time as may be allowed by the EUTF.

No contract shall be considered binding upon the EUTF until the contract has been fully and properly executed by all parties thereto.

If the offeror to whom a contract is awarded shall fail or neglect to enter into the contract within ten days after award or within such further time as may be allowed, the Procurement Officer will consider the next highest ranked offeror or may call for new proposals, if it is deemed to be in the best interests of the EUTF.

XVII. Availability of Funds

Any contract resulting from this RFP shall be enforceable only to the extent that funds are available to the EUTF to make payments to the contractor. All payments to the contractor are subject to the EUTF's actual and continuing availability of funds. No damages or interest shall accrue against the EUTF, the State, the counties, or any other public employer as a result of the non-availability of funds.

Contractor acknowledges that the funds available to the EUTF come from public employer and employee-beneficiary contributions. With respect to retirees, HRS Chapter 87A establishes the amount of the public employer contributions. However, with respect to active employees, the public employer contributions are generally established by collective bargaining between the public employers and public sector unions, and such contributions are subject to appropriation by the legislative bodies of the State and counties. See HRS §§ 87A-32, 89-9(a), 89-9(e), 89-10(b), and 89-11(g). Thus, a significant portion of the EUTF's availability of funds is contingent upon future collective bargaining between the public employers and public sector unions, the terms of any resulting collective bargaining agreements, and future appropriations by the legislative bodies of the State and counties.

The EUTF shall have the following rights should there not be available funding for contractor's contract: (a) to cancel the award of contract; (b) to renegotiate the award of contract to purchase reduced or modified services; (c) to delay the commencement date of the contract; or (d) to terminate the entire contract or any part thereof.

XVIII. Requirements for Doing Business in the State of Hawaii

Section 3-122-112, Hawaii Administrative Rules ("HAR"), requires that, before award of contract may be made, the successful offeror must provide proof of compliance with the requirements of the following chapters of the Hawaii Revised Statutes ("HRS"):

1) Chapter 237, general excise taxes
2) Chapter 383, unemployment insurance
3) Chapter 386, workers' compensation
4) Chapter 392, temporary disability insurance
5) Chapter 393, prepaid health care

And one of the following:

1) Be registered and incorporated or organized under the laws of the State of Hawaii, or
2) Be registered to do business in the State of Hawaii.

Reference Responsibility of Offerors in §3-122-112, HAR. Offeror shall produce documents to the Procurement Officer to demonstrate compliance with this section.

HRS Chapter 237 tax clearance requirement for award and final payment.

Pursuant to §103D-328, HRS, the successful offeror shall be required to submit a tax clearance certificate issued by the Hawaii State Department of Taxation (DOTAX) and the Internal Revenue Service (IRS). The certificate is valid for six (6) months from the most recent approval stamp date on the certificate and must be valid on the date it is received by the purchasing agency. The tax clearance certificate shall be obtained on the State of Hawaii, DOTAX TAX CLEARANCE APPLICATION Form A-6 (Rev.2003) which is available at the DOTAX and IRS offices in the State of Hawaii or the DOTAX website, and by mail or fax:

DOTAX Website (Forms & Information): http://www.state.hi.us/tax/alphalist.html

DOTAX Forms by Fax/Mail: (808) 587-7572
1-800-222-7572

Completed tax clearance applications may be mailed, faxed, or submitted in person to the Department of Taxation, Taxpayer Services Branch, to the address listed on the application. Facsimile numbers are:

DOTAX: (808) 587-1488
IRS: (808) 539-1573

The application for the clearance is the responsibility of the offeror, and must be submitted directly to the DOTAX or IRS and not to the purchasing agency.

Contractor is required to submit a tax clearance certificate for final payment on the contract. A tax clearance certificate, not over two months old, with an original green certified copy stamp, must accompany the invoice for final payment on the contract.

In addition to a tax clearance certificate an original "Certification of Compliance for Final Payment" (SPO Form 22), attached, will be required for final payment. A copy of the Form is also available at www.spo.hawaii.gov.

HRS Chapters 383 (Unemployment Insurance), 386 (Workers' Compensation), 392

(Temporary Disability Insurance), and 393 (Prepaid Health Care) requirements for award.

Pursuant to §103D-310(c), HRS, the successful offeror shall be required to submit an approved certificate of compliance issued by the Hawaii State Department of Labor and Industrial Relations (DLIR). The certificate is valid for six (6) months from the date of the issue and must be valid on the date it is received by the purchasing agency.

The application for certificate of compliance (Form LIR #27) can be obtained from the DLIR website:

http://www.dlir.state.hi.us/forms/ApplicationforCertificateofCompliance.pdf or from:

DLIR Administrative Services Office
830 Punchbowl Street, Room 309
Honolulu, HI 96813
Phone: (808) 586-8888
Fax: (808) 586-8899

The DLIR will return the form to the offeror who in turn shall submit it to the purchasing agency. The application for the Certificate is the responsibility of the offeror, and must be submitted directly to the DLIR and not to the purchasing agency.

Business registration.

Hawaii business. A business entity referred to as a "Hawaii business" is registered and incorporated or organized under the laws of the State of Hawaii. As evidence of compliance, offeror shall submit a CERTIFICATE OF GOOD STANDING issued by the Department of Commerce and Consumer Affairs Business Registration Division ("BREG"). A Hawaii business that is a sole proprietorship, however, is not required to register with the BREG, and therefore not required to submit the certificate. An offeror's status as sole proprietor or other business entity and its business street address indicated on Proposal Letter will be used to confirm that the offeror is a Hawaii business.

Compliant non-Hawaii business. A business entity referred to as a "compliant non-Hawaii business" is not incorporated or organized under the laws of the State of Hawaii but is registered to do business in the State. As evidence of compliance, offeror shall submit a CERTIFICATE OF GOOD STANDING.

To obtain a CERTIFICATE OF GOOD STANDING go online to www.businessregistrations.com and follow the instructions. To register or to obtain a "Certificate of Good Standing" by phone, call (808) 586-2727 (M-F 7:45 am to 4:30 pm-HST). The "Certificate of Good Standing" is valid for six (6) months from date of issue and offerors are advised that there are costs associated with registering and obtaining a "Certificate of Good Standing" from the BREG.

The above certificates should be applied for and submitted to the purchasing agency as soon as possible. If a valid certificate is not submitted on a timely basis for award of the contract, an offeror otherwise responsive and responsible may not receive the award.

Alternately, instead of separately applying for these certificates at the various state agencies, Offerors may choose to use the Hawaii Compliance Express (HCE), which allows businesses to register online through a simple wizard interface at http://vendors.ehawaii.gov to acquire a "Certificate of Vendor Compliance." The HCE provides current compliance status as of the issuance date. The "Certificate of Vendor Compliance" indicating that vendor's status is compliant with the requirements of Chapter 103D-310(c), HRS, shall be accepted for both contracting and final payment purposes. Offerors that elect to use the new HCE services will be required to pay an annual fee of $15.00 to the Hawaii Information Consortium, LLC (HIC). Offerors choosing not to participate in the HCE Program are required to submit the paper certificates as instructed in previous paragraphs

XIX. Special Conditions

The following Special Conditions will supplement the General Conditions of the Contract:

1. Certificate of Authority/License. Prior to the effective date of the contract and during the entire term of the contract, the contractor shall obtain and maintain all certificates of authority, licenses, and other approvals necessary to lawfully provide all benefit plans required under the contract and/or to lawfully provide all services required under the contract. By accepting the award of contract, contractor certifies that: (a) it has all certificates, licenses, and approvals necessary to lawfully provide all benefit plans and/or services required under the contract; and (b) if applicable, that its benefit plans comply with all applicable federal, state, and county laws.

2. Compliance with EUTF Laws and Rules. The contractor shall comply with: Chapter 87A, HRS, as the same may be amended from time to time; all rules, policies, standards, procedures, and directives adopted by the Board; and all policies, standards, procedures, and directives of the Administrator. The contractor shall be bound by the Board's interpretation of Chapter 87A, HRS, and the EUTF's rules, policies, standards, procedures, and directives.

3. Records. Consistent with industry standards and practices, the contractor shall maintain reasonable records pertaining to the contractor's provision of all the benefit plans and/or services required under the contract and contractor's performance of the contract including, but not limited to: (a) enrollment and eligibility records; (b) claims records; and (c) financial and accounting records showing all financial transactions pertaining to contractor's provision of benefit plans and/or services, contractor's performance of the contract, and all payments received or due to contractor under or relating to the contract. Unless otherwise agreed by the EUTF, all such records shall be kept and maintained in the State of Hawaii. Except as otherwise required by law, contractor shall maintain all records for at least three (3) years from the date of final payment under the

contract. Records which relate to an appeal, litigation, or settlement of claims arising out of the contract shall be retained by contractor for at least three (3) years after the subject appeal, litigation, or claim has been disposed of or otherwise resolved.

4. Accounting. Except as otherwise required by law, the contractor's accounting procedures and practices shall conform to generally accepted accounting principles consistently applied and all fees and costs applicable to the contract shall be readily ascertainable from the contractor's records.

5. Inspections and Audits. At all times that it is required to maintain records under the contract, contractor shall make such records available at its local office for inspection or audit by authorized representatives of the EUTF, the State Auditor, and/or the State Comptroller. Such inspections and audits may include, but are not limited to: (a) claims audits; (b) audits relating to the performance standards and guarantees required under the contract; (c) audits relating to contractor's performance of the contract and compliance with the contract's terms and conditions; and (d) the contractor's claimed fees, costs, and expenses. To the extent that contractor proposes to use or uses any subcontractors to fulfill its obligations under the contract, those subcontractors must agree to abide by the record keeping, accounting, and audit requirements of the contract.

6. Liquidated Damages. In the event of any breach of the contract by contractor, liquidated damages shall be assessed against contractor in the sum of Five Thousand and No/100 Dollars ($5,000) per calendar day until the breach is remedied by contractor.

7. Insurance. At its sole cost and expense, the contractor shall obtain and keep in force throughout the entire term of the contract and any extensions thereof, the following types of insurance, in the minimum amounts specified and in the form hereinafter provided for:

   (a) An insurance policy or policies that cover claims resulting from the contractor's negligent or willful acts, errors or omissions, breach of contract, breach of fiduciary or other duty, violation of statute or other law, in providing services under the contract. The policy or policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board. Initially, the insurance policy must have limits of liability in the amount of at least FIVE MILLION AND NO/100 DOLLARS ($5,000,000), per occurrence and in the aggregate. The insurance policy shall be endorsed to provide that it is primary insurance and not contributing or excess over any coverage that the EUTF, Board or State of Hawaii may carry.

   (b) A fidelity bond, commercial crime policy, or other equivalent insurance that provides insurance coverage or similar protection to the EUTF against forgery, theft, robbery, fraud, dishonest and criminal acts committed by any of the contractor's employees that causes the EUTF to sustain monetary loss. The limits of such bond or policy shall be FIVE MILLION AND NO/100 DOLLARS ($5,000,000) per occurrence and in

the aggregate.

(c) Any and all other insurance that is required by applicable law and that is reasonably necessary in order for contractor to perform the work and services required under the contract. The insurance policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board, as measured by what a reasonably prudent trustee would require of a contractor in similar circumstances.

The adequacy of the coverage afforded by the contractor's insurance shall be subject to review by the Board, from time to time, and if it appears that a reasonably prudent trustee, operating a trust fund similar to that operated by the Board, would require an increase in the limits of liability of such insurance, contractor shall to that extent take all necessary actions to increase such limits.

All the required insurance shall be carried with insurance carriers that have a general policyholder's rating of not less than A and a financial rating of no less than VII in the most current Best's Insurance Reports. If the Best's ratings are changed or discontinued, the parties shall agree to an equivalent method of rating insurance companies.

Throughout the entire term of the contract, the EUTF, the Board and its trustees shall be named as additional insureds on all the insurance policies required hereunder. At the commencement of the contract, the contractor shall provide the Board with certificates of insurance showing that it is carrying all the insurance required hereunder. At or prior to the expiration of all insurance policies required hereunder, the contractor shall provide the Board with certificates of insurance showing the renewal or replacement of such insurance policies. All policies of insurance shall provide that the Board will be given thirty (30) days notice in writing in advance of any cancellation, lapse or reduction in the amount of insurance.

Each insurance policy required by this contract, including a subcontractor's policy, shall contain the following clauses:

(1) "This insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days written notice has been given to the Hawaii Employer-Union Health Benefits Trust Fund, 201 Merchant Street, Suite 1520, Honolulu, Hawaii 96813."

(2) "The State of Hawaii is added as an additional insured with respect to operations performed for the State of Hawaii."

(3) "It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy."

The minimum insurance required shall be in full compliance with the Hawaii Insurance Code throughout the entire term of the contract, including supplemental agreements.

Upon contractor's execution of the contract, the contractor agrees to deposit with the State certificate(s) of insurance necessary to satisfy the State that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificate(s) therefore on deposit with the State during the entire term of this contract, including those of its subcontractor(s), where appropriate.

Upon request by the State, contractor shall be responsible for furnishing a copy of the policy or policies.

Failure of the contractor to provide and keep in force such insurance shall be regarded as material default under this contract, entitling the State to exercise any or all of the remedies provided in this contract for a default of the contractor.

The procuring of such required insurance shall not be construed to limit contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract

8. Transition Procedures. At no cost to the EUTF, the contractor shall comply with the following provisions upon receipt of a notice of termination or upon the expiration of the contract:

(a) As directed by the EUTF, the contractor shall terminate or assign to the EUTF or its designee any outstanding orders or contracts that relate to contractor's performance of the contract.

(b) The contractor shall transfer title and deliver to the EUTF or its designee any and all completed or partially completed goods, materials, reports, information, or other work product of the contractor that were made under the contract or as part of the contractor's performance of the contract.

(c) As directed by the EUTF, the contractor shall destroy and/or deliver to the EUTF or its designee all confidential or proprietary documents, information, and data that contractor has received under the contract and all copies thereof.

(d) The contractor shall provide to the EUTF or its designee all records, documents, information, and data reasonably necessary to allow the EUTF or its designee to continue to provide and/or administer, without interruption, all health and other benefit plans to EUTF beneficiaries, and to comply with all federal, state, and other legal requirements to which the EUTF is subject. Such records, documents, information, and data shall include, but not be limited to, eligibility information and data, claims experience or history data, and administrative records.

(e) As directed by the EUTF, the contractor shall handle retroactive enrollments for persons who should have been enrolled prior to the

effective date of the termination or expiration, the run-off of all claims incurred prior to the effective date of the termination or expiration, and any other requirements of the contract that apply to the period of time prior to the effective date of the termination or expiration.

(f) The contractor shall provide the EUTF with a final accounting of claims, premiums, reserves, and retention covering the last unreported period of time up to and including the effective date of termination or expiration, a final monthly operation report, a final plan performance and paid accounting report, and a final quarterly report on financial operations and performance standards.

PROPOSAL

I. Proposal Preparation

This section of the RFP describes the proposal format, content, and requirements. The intent is to standardize proposals to a degree where comparisons may be made among the proposals using equitable measurements. This is not an attempt to limit the contents of any proposal and an offeror may include any additional information that it deems to be pertinent and that it believes would assist the Evaluation Committee in its review of the offeror's proposal. The proposal should be written in a clear, straightforward way, describing the offeror's response to the requirements of this RFP. The proposal should not include materials that are not essential to the proposal's utility and clarity.

Each responsive proposal will be reviewed by the Evaluation Committee (or its designees) for conformity with the requirements of the RFP. If asked for additional information by the Procurement Officer, offerors shall respond within two (2) business days, unless otherwise directed by the Procurement Officer.

Each proposal shall contain the following sections:

Section I:	Proposal Transmittal Letter
Section II:	Offer Form OF-1
Section III:	Executive Summary
Section IV:	Project Approach, Responses to Questions
Section V:	Organization and Staffing
Section VI:	Offeror Background and Experience
Section VII:	Price
Section VIII:	Certification
Attachment A:	Staff Resumes
Attachment B:	Offeror's References
Attachment C:	Offeror's Tax Clearance
Attachment D:	Wage Certification

II. Proposal Transmittal Letter

A transmittal letter must be included as part of the proposal. The transmittal must be on the offeror's business letterhead, signed by an individual authorized to legally bind the offeror, dated, notarized, and be affixed with the offeror's corporate seal, if any. Evidence shall be submitted showing the individual's authority to bind the offeror, e.g., corporate resolution, bylaws, etc.

The proposal transmittal letter shall also contain the following:

A. Contact Person

The letter shall include the name of a duly authorized person that the EUTF is to contact regarding the offeror's proposal, and that person's address, telephone/fax numbers, and e-mail address.

B. Terms and Conditions of RFP

A statement that the offeror understands and will comply with all terms and conditions of the RFP. If an offeror does not plan to comply with any of the terms or conditions of the RFP, this must be stated and all exceptions listed and fully described. If an offeror proposes any additional terms and conditions (including group plan service agreements, benefit schedules, prescription drug riders, or other similar documents), this must be stated and copies of all such additional terms and conditions must be provided as part of the offeror's proposal.

The offeror must include written acknowledgement of receipt of any and all amendments or addenda made to this RFP.

C. Legal Entity

A statement indicating that the offeror is an individual, a partnership, a limited liability company, a corporation, or other legal entity. If the offeror is a corporation, a partnership, a limited liability company or other legal entity, the letter must state: (1) the date offeror was incorporated or organized; (2) the place where the offeror was incorporated or organized; (3) the offeror's principal place of business; (4) all states where the offeror is authorized to transact business; and (5) the names of all the offeror's parent, affiliate, and subsidiary organizations.

D. Authorized Signature

The letter must be signed by an individual or individuals authorized to legally bind the offeror. If the offeror is a corporation, evidence in the form of a certified copy of a corporate resolution or certified copy of articles of incorporation or bylaws shall be submitted showing the individual's authority to bind the corporation. If the offeror is a partnership, the proposal must be signed by all the partners or evidence in the form of a certified copy of the partnership agreement shall be submitted showing the individual's authority to bind the partnership. Similar evidence must be submitted for an individual signing the proposal letter on behalf of any other kind of entity.

E. Assumptions or Constraints

A statement on whether the proposal contains any assumptions or constraints and identifying and describing each such assumption and constraint. If neither assumptions nor constraints are included in the offeror's proposal, a statement to that effect must be made.

F. Deviations

If the proposal deviates from the specifications or requirements of the RFP, a statement must be included identifying and describing each such deviation. If no deviations are included in offeror's proposal, a statement to that effect must be made.

G. Federal Tax ID No.

The letter shall include the offeror's federal tax identification number.

H. Hawaii General Excise Tax ID No.

A Hawaii General Excise Tax (GET) ID must be provided or a representation that a Hawaii General Excise Tax ID will be obtained prior to commencement of the work.

I. Current Licenses and Registration

A statement that the offeror maintains the current licenses necessary to provide the services required. In addition, an offeror must provide evidence that the offeror is registered to do business in the State of Hawaii prior to commencement of the work. True and accurate copies of the offeror's license(s) and certificates must be provided.

J. Subcontracting of Services

A statement by the offeror indicating that the services and work described in the RFP will be performed by the offeror and will not be subcontracted, except as described in the proposal, or assigned without the prior written approval of the Contract Administrator. The extent to which the work will be subcontracted and the qualifications of any subcontractor will be considered in evaluating the offeror's ability to perform the service referred to in the RFP.

K. Non-discrimination

A statement of affirmative action stating that the offeror does not discriminate in employment and practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, handicap or disability must be included.

L. Terms and Conditions of Contract

Affirm that the offeror understands and accepts the provisions of the sample contract in Appendix C (including the General Conditions) or state with specificity any and all proposed modifications. If no modifications are stated, the contractor will be deemed to have understood and accepted all of the provisions of the sample contract in Appendix C (including the General Conditions). The EUTF reserves the right to decline or classify as "unresponsive" any substantive changes, modifications, or revisions to the provisions of the sample contract.

III. Offer Form OF-1

Include a signed Offer Form OF-1 Appendix F with the exact legal name of the offeror as registered with the Department of Commerce and Consumer Affairs, if applicable, offeror's address, and the name, mailing address, and telephone and fax number (s) of the person the EUTF should contact regarding offeror's proposal.

The authorized signature on the first page of the Offer Form shall be an original signature in ink. If unsigned or the affixed signature is a facsimile or a photocopy, the offeror's proposal may be rejected unless accompanied by other material, containing an original signature that shows that the proposal is legally binding on the offeror.

IV. Executive Summary

The executive summary shall clearly and concisely summarize and highlight the contents of the proposal in such a way as to provide the Evaluation Committee with a broad understanding of the entire proposal.

V. Project Approach, Responses to Questions

Provide a description of the offeror's approach and methodology to accomplish the scope of work as set forth in this RFP. Include responses to the questions presented in Appendix D of this RFP that are applicable to offeror's proposal.

VI. Organization and Staffing

This section shall include information on the experience and professional qualifications of the offeror's staff who will be assigned to perform the work and services required under the RFP (the "project").

Included in Attachment A, STAFF RESUMES, of the proposal shall be a resume of each individual who will be assigned to this project. Resumes shall highlight experiences on specific projects that may be relevant to this project. Resumes should contain information relating to each person's experience, education, and skills. This should include, but is not limited to, names of employers, position titles, educational institutions attended, degrees and certifications obtained, and membership in professional associations.

VII. Offeror Background and Experience

This section shall include a list of similar clients. The list should include large (over 5,000 employees) clients, government clients, and clients in Hawaii.

Included in Attachment B, OFFEROR'S REFERENCES, of the proposal shall be responses to the questions presented in Appendix D (Questions for Offerors) of this RFP. Offeror grants the EUTF authorization to contact any of the offeror's previous clients, including these client references, to evaluate the offeror and its work.

Included in Attachment C, OFFEROR'S TAX CLEARANCE, of the proposal shall be an original or certified copy of a tax clearance issued by the Hawaii State Department of Taxation (DOTAX) and the Internal Revenue Service (IRS). These must be submitted with the offeror's proposal. The tax clearance shall be obtained on the two-part Tax Clearance Application (Form A-6) that combines DOTAX and IRS tax clearances.

Tax clearance submitted with a sealed offer must be valid on the date that it is submitted or any date thereafter up to the proposal due date. A valid tax clearance received with an offer will remain valid for the contract award.

VIII. Price

The offeror's quoted price shall be a fixed cost for: (a) the first nine months of the term of the contract; and (b) the following 12 months of the term of the contract. The offeror's quoted price for each of the two optional one-year extensions of the contract and for the optional two-year extension of the contract shall include a maximum trend rate and retention rate as is more particularly described in Section V.B., item 15 of the Scope of Work. The offeror's quoted prices shall include all premiums, compensation, fees, costs, expenses, and other amounts (including all applicable taxes) that offeror will charge the EUTF if it is awarded a contract resulting from this RFP. The offeror shall submit its price quotations on Rate Proposal Forms (Appendix E).

Payments to each contractor shall be per Section 103-10, HRS. If an offeror desires any additional terms or provisions regarding the method of payment, the terms or provisions must be set forth in the offeror's proposal.

IX. Certification

The proposal shall include a certification that:

> The quoted prices and other parts of the proposal were arrived at independently, without consultation, communication, or agreement with any other offeror or competitor.
>
> Unless otherwise required by law, the quoted prices and other parts of the proposal that were submitted have not been knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor prior to the award of the contract.

No attempt was made or will be made by each offeror to include any other person or firm to submit or not to submit a price for the purpose of restricting competition.

X. Offer Guaranty

No offer guaranty is required for this RFP.

XI. Performance and Payment Bonds

No performance bond is required for this RFP.

XII. Confidential Information

The offerors' proposals and all information, data, and other material provided by the offeror to the State shall be subject to the Uniform Information Practices Act, Chapter 92F, HRS. The offeror shall designate in writing to the Procurement Officer those portions of its proposal that contain trade secrets or other proprietary data that are to remain confidential subject to Section 3-122-58, HAR. The offeror shall state in its written communication to the Procurement Officer, the reasons for designating the material as confidential. The offeror shall submit the material designated as confidential in such manner that the material is readily separable from the rest of offeror's proposal in order to facilitate inspection of the non-confidential portion of the proposal.

Offerors should note that they cannot designate their prices as confidential. Following award of the contract, all offerors' proposed prices will not be withheld from disclosure as confidential.

PROPOSAL EVALUATION

I. Introduction

The EUTF seeks to retain the highest quality organization to provide insured medical plans. Throughout the selection process, the EUTF reserves the right, in its sole discretion:

1. To not award the contract to the lowest cost offeror.
2. To not award the contract at all.

II. Evaluation Process

An Evaluation Committee selected by the Procurement Officer and the EUTF Board will review and evaluate all proposals submitted by the deadline specified in this RFP. All proposals shall be kept confidential until a contract is awarded.

The evaluation process will be conducted in five phases:

Phase 1 - Evaluation of Mandatory Requirements
Phase 2 - Establishment of Priority List of Offerors
Phase 3 - Interviews with Priority-Listed Offerors
Phase 4 - Final Evaluation of Proposals
Phase 5 - Award

III. Phase 1 – Evaluation of Mandatory Requirements

The evaluation of the mandatory requirements shall be on a "pass/no pass" basis. The purpose of this phase is to determine whether an offeror's proposal is sufficiently responsive to the RFP to permit a complete evaluation. Each proposal will be reviewed for responsiveness. Failure to meet the mandatory requirements ("no pass") will be grounds for deeming the proposal non-responsive to the RFP and rejection of the proposal. Only those proposals meeting the following mandatory requirements ("pass") of Phase 1 will be considered in Phase 2:

- Offeror must have been in business for a minimum of five (5) years.
- Offeror must provide insured benefit plans to large multi-employer trust funds (preferably including public plans)
- Offeror must be based in the United States. "Based in the United States" means that offeror's principal place of business is in the United States and that offeror is subject to service of process in the United States.
- Submission of Financial Statement.
- Submission of a complete Proposal Transmittal Letter.

- Submission of a proposal that contains references, premium proposal and sample reports.

IV. Phase 2 – Establishment of Priority List of Offerors

All offerors who pass Phase 1, Evaluation of Mandatory Requirements, shall be classified as "acceptable." If there are more than three "acceptable" offerors, the Evaluation Committee will evaluate all proposals and establish a priority list of no more than three (3) offerors who received the best preliminary evaluations (the "priority-listed offerors"). The acceptable offerors or, if applicable, the offerors on the priority list are hereafter referred to as the "priority-listed offerors". The criteria for this preliminary evaluation and the points to be applied to each evaluation criteria are as follows:

CRITERIA	POINTS
Demonstrated Competence (to include but not limited to plan design and provider access) and expertise/availability of key personnel	10
Experience in performance of comparable engagements	10
Conformance with the terms of this RFP	20
Cost	60
TOTAL	100

The evaluation criteria are more specifically described in Paragraph VIII below.

V. Phase 3 – Interviews with Priority-Listed Offerors

In this phase, the Evaluation Committee and the Procurement Officer may conduct interviews with the priority-listed offerors in Honolulu during the period of July 27 - 29, 2009.

VI. Phase 4 – Final Evaluation of Proposals

In this phase, the Evaluation Committee will conduct final evaluations of the proposals of the priority-listed offerors.

A. The criteria for the final evaluation of proposals and the points to be applied to each evaluation criteria are as follows:

CRITERIA	POINTS
Demonstrated Competence (to include but not limited to plan design and provider access) and expertise/availability of key personnel	10
Experience in performance of comparable engagements	10
Conformance with the terms of this RFP	20
Cost	60
TOTAL	100

The evaluation criteria are more specifically described in Paragraph VIII below.

B. The Evaluation Committee may contact the references provided in response to the Section identified as Offeror Background and References; contact any offeror to clarify any response; contact any current users of an offeror's services; solicit information from any available source concerning any aspect of a proposal; and seek and review any other information deemed pertinent to the evaluation process. The evaluation committee shall not be obligated to accept the lowest priced proposal, but shall make an award in the best interests of the EUTF and its members.

C. Each offeror must include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the offeror or in which the offeror has been judged guilty or liable. Failure to comply with the terms of this provision may disqualify any proposal. The EUTF reserves the right to reject any proposal based upon the offeror's prior history with the EUTF or with any other party, which documents, without limitation, unsatisfactory performance, adversarial or contentious demeanor, significant failure(s) to meet contract milestones or other contractual failures.

D. The Evaluation Committee may conduct or designate the Procurement Officer to conduct clarification discussions with offerors who submit proposals determined to be acceptable and competitive. Offerors shall be accorded fair and equal treatment with respect to any opportunity for discussion and/or written revisions of proposals. Such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by competing offerors.

E. A Notification of Intent to Award shall be issued. Any award is contingent upon the successful negotiation of final contract terms and upon approval of the Board of Trustees. Negotiations shall be confidential and not subject to disclosure to competing offerors unless and until an agreement is reached. If contract

negotiations cannot be concluded successfully, the EUTF upon written notice to all offerors may negotiate a contract with the next highest scoring offeror or withdraw and cancel the RFP.

F. Any contract resulting from this RFP shall not be effective unless and until approved by the Board of Trustees of the EUTF.

VII. Phase 5 – Award

The EUTF Board will make the final selection.

VIII. Evaluation Criteria

Below is a brief description of the evaluation criteria that will be used to evaluate the proposals. These definitions are not intended to be all encompassing.

1. Demonstrated competence (to include but not limited to plan design and provider access) and expertise/availability of key personnel. Did the offeror provide sufficient documentation to establish that it will do a good job for the EUTF? Was the proof compelling? Does the offeror have the personnel, facilities, assets, contractual arrangements, subcontractors, resources, knowledge, skills, capabilities and abilities to perform the scope of work required by this RFP well? Will the offeror's resources, knowledge and skills be adequate to serve EUTF's needs? Does the offeror suggest new ways to enhance performance (e.g., alternative plan design)? Does the offeror have the flexibility and capacity to handle all the needs of EUTF as they continue to change (e.g., exclusive provider network)? Did the offeror present a sufficient performance history to convince you of its capabilities and abilities? Has the offeror been in business long enough to provide good stability? Has the offeror experienced ownership changes that would impact its services? Has there been any censure or litigation history? Is the staff that will be assigned to this project by the offeror the best qualified to complete the tasks? Will they be available for follow-up issues? Is sufficient staff assigned to handle these duties?

2. Experience in performance of comparable engagements. Does the offeror have prior experience that shows that the offeror has all the personnel, facilities, assets, contractual arrangements, subcontractors, resources, knowledge, skills, capabilities and abilities to ensure that it can and will perform the scope of work and all tasks required by this RFP well? Did the offeror have success in providing similar services and performing similar work for similar private or governmental entities? Does the offeror's previous work convince you of its successful completion of these duties? Has the offeror provided adequate references?

3. Conformance with the terms of this RFP. Did the offeror's proposal clearly show that the offeror will comply with all the terms and conditions of the RFP and the provisions of the sample contract in Appendix C (including the General Conditions)? Has the offeror proposed unacceptable or undesirable modifications to the terms and conditions of the RFP and the provisions of the sample contract? Did the offeror's proposal provide all the necessary information requested in the RFP in a professional

manner? Did the proposal cause doubt regarding its ability to complete the necessary tasks? Was the proposal easy to understand and did it provide answers to questions, or create more questions?

4. Cost. Cost will be scored based on the total cost of the first 21 month contract period. The lowest cost proposal will receive the full possible points. Other proposals will be awarded points in proportion to the lowest cost proposal as follows:

Formula for determining allocation of points for fee for the first 21 months: allocated points = ($ amount of the lowest fee proposal) ÷ ($ amount of the fee proposal being evaluated) x 60.

SCOPE OF WORK

I. Introduction

The purpose of the contract resulting from this RFP is to obtain the services of qualified insurers to provide insured medical benefit plans for active employees and/or retirees effective upon award of the contract. Contract(s) awarded pursuant to this RFP may be implemented immediately to replace current EUTF self funded medical benefit plans.

The contractor will enter into a contract in substantially the form set forth in Appendix C which will obligate the contractor to provide insured medical plans.

II. Contract Period

The term of the contract is twenty one (21) months with possible extensions exercisable at the sole option of the EUTF Board. The term of the contract will commence on or around October 1, 2009. The EUTF Board will have the sole discretion to determine whether or not to exercise extension options as provided herein (Section VI.B.15).

The term of the contract may be extended by the EUTF Board, at its sole option, to facilitate the completion of the contract. Such extension shall be solely for the purpose of completing the contract services and shall be at no additional cost to the EUTF.

III. Funding

Execution of any contract(s) between the EUTF and the successful offeror(s) is contingent upon the availability of funds. In addition, any contract(s) resulting from this RFP shall be enforceable only to the extent of the availability of funds. No damages or interest shall accrue against the EUTF or the State as a result of the non-availability of funds.

Depending on the prices proposed, the currently available funding may be insufficient to support the entire scope of work required under this RFP and/or proposed by the offeror(s). If the currently available funding is insufficient to support the entire scope of work, the EUTF reserves the right to negotiate with the offeror(s) to: (a) reduce the price(s) and/or scope of work that will be included in any contract(s) resulting from this RFP; (b) make any such contract(s) or any parts thereof contingent on the EUTF receiving further available funding; and/or (c) delay implementation of any such contract(s) or any parts thereof pending the EUTF receiving further available funding. However, the evaluation of the offerors' proposals shall be based on the proposals satisfying the entire scope of work required by this RFP regardless of whether the currently available funding is sufficient for that scope of work.

To the extent that any contract(s) resulting from this RFP permits the EUTF to extend the term of the contract beyond the initial 21-month term, the mutual obligations of both parties for and during any optional extension period(s) are subject to the appropriation and availability of funds. See HAR § 3-122-149 (Multi-term contract).

IV. Liaison and Authorization to Proceed

The EUTF Administrator as Contract Administrator will serve as the primary liaison with the contractor during the term of the contract.

The offeror's Primary Contact will serve as the primary liaison with the EUTF during the term of the contract.

V. Scope of Services

A. Objective

The EUTF is requesting proposals from qualified insurers to provide insured medical benefit plans for active employees and/or retirees effective upon award of the contract. Contract(s) awarded pursuant to this RFP may be implemented immediately to replace current EUTF self funded medical benefit plans. The EUTF's current plans as well as alternate plan options under consideration by the Board are described in Appendix N.

Each offeror is free to submit proposals on plan designs that differ from the plan designs described in the questionnaires in Appendix D.

B. Specifications

1. Instructions

This Section sets out specifications for the benefit plans and services that the EUTF is seeking through this RFP. Unless an offeror expressly and specifically makes an exception to or identifies a deviation from these specifications in its proposal, the offeror's proposal will be deemed to offer to meet and abide by all specifications set forth in this Section. If an offeror proposes an exception to or a deviation from any of the contractual requirements set forth in this RFP, the offeror's proposal must specifically and completely describe and delineate that exception or deviation. Otherwise, the offeror's proposal will be deemed to accept and agree to all the contractual requirements. The EUTF is under no obligation to agree to any exception or deviation proposed by an offeror, and will take any such exceptions and deviations into account in evaluating the offeror's proposal.

This Section also identifies questionnaires (Appendix D) that each offeror must answer in its proposal. Each offeror has the option of answering the questions via electronic file upon request. The EUTF will take into account any failure of an offeror to clearly and adequately provide answers to the questionnaires.

2. Basic Services

Contractor shall provide the benefits and services that are: (1) required under this RFP; (2) proposed by contractor and accepted by the EUTF; and (3) otherwise required under the contract between the contractor and the EUTF.

3. Customer Service Office

During the entire term of the contract, the contractor shall have and maintain a customer service office located in the State of Hawaii. Personnel, systems, and equipment at the customer service office shall be reasonably sufficient to provide all the customer services proposed by contractor and required under the contract.

4. Key Personnel

Within thirty (30) calendar days of the award of contract, the contractor shall notify the EUTF in writing of the names, titles, business addresses, e-mail addresses, telephone numbers, and areas of responsibility of all of its authorized representatives. The authorized representatives shall be available to answer questions from or hold discussions with the Board or its designee, the Administrator, EUTF staff, the Consultant or the Attorney General's office with respect to contractor's benefits plans, contractor's performance of the contract, or any matter pertaining to the EUTF. The contractor shall give the EUTF at least ten (10) days notice in advance of any change in the authorized representatives.

Among the authorized representatives, contractor shall designate a contract liaison officer who shall be responsible to the EUTF for contractor's performance of the contract. The contract liaison officer shall attend all meetings called by the Board or its designee, the Administrator, or the Consultant.

5. Eligibility

Eligibility of EUTF employee-beneficiaries and dependent-beneficiaries for enrollment in and coverage by contractor's benefit plans shall be determined under HRS Chapter 87A and the EUTF's administrative rules. Contractor shall be bound by the EUTF's determinations regarding eligibility of EUTF employee-beneficiaries and dependent-beneficiaries.

Contractor shall accept enrollment and cancellation dates as stated in EUTF transmissions, reports, or files. Contractor shall accept enrollment eligibility dates for Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage in accordance with federal law as determined by the Administrator and the public employers' departmental personnel officers.

Contractor shall waive all pre-existing conditions provisions and all actively at work and dependent deferment requirements for EUTF employee-beneficiaries and dependent-beneficiaries to be covered on the effective date.

6. Processing Enrollments, Cancellations and Terminations

Twice a month (semi-monthly), the EUTF will provide a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant electronic data transmission that shows new enrollments, cancellations, terminations, and other changes applicable to contractor's benefits plan(s). Subject to the following, contractor shall process such enrollments, cancellations, terminations, and changes in a timely manner:

Within fifteen (15) calendar days of the electronic data transmission, a contractor for health benefits shall enroll all new enrollees in its health benefits plan(s) and mail I.D. cards to the new enrollees. In addition, contractor shall process all cancellations and termination of enrollments within 24 hours of the electronic data transmission.

Between the dates that the EUTF makes the electronic data transmissions, the EUTF may request the contractor to perform new enrollments or other changes to enrollment. Contractor shall accept such requests and perform the requested enrollments or other changes in a timely manner. New enrollments shall be performed no later than fifteen (15) calendar days after receipt of the EUTF's request.

7. Provision of Information/Telephone Access

Contractor shall have knowledgeable staff available to answer inquiries from EUTF staff and EUTF employee-beneficiaries and dependent beneficiaries regarding: (1) the benefits provided by contractor; (2) contractor's benefit plans, forms, and procedures; (3) enrollment status; (4) premium costs; (5) claims and claim procedures; (6) COBRA; and (7) other matters pertaining to the benefit plans provided under the contract. If contractor does not maintain neighbor island offices, contractor shall provide a toll-free telephone line to answer such inquiries. Contractor's office and the toll-free telephone line shall be open during all State of Hawaii business hours.

At its own cost, contractor shall draft, print, and regularly update written information that describes its benefit plan in detail and a list of its providers. Upon request, the written information and list shall be provided to the EUTF's employee-beneficiaries and dependent-beneficiaries.

8. Open Enrollment

Each year, the EUTF holds at least two open enrollment periods; one for active employees ("active" or "actives") and one for retired employees ("retiree" or "retirees"). Historically, active open enrollment period begins in April and retiree open enrollment period begins October. The EUTF may also hold special open enrollment periods during other times of the year.

Prior to open enrollment periods, the Administrator solicits summary benefit plan information from all contractors that explain and update their benefit plan coverages, exclusions, limitations, service locations, networks and mail order providers, etc. The Administrator then coordinates the publishing and distribution of benefit plan booklets, news bulletins, notices, enrollment applications, and other forms related to the open enrollment. The Administrator may also require the contractor to develop audio and video presentations on its benefit plans on electronic media (e.g., CD/DVD) at the contractor's own cost. Contractor shall provide all information requested by the Administrator in a timely fashion.

During the open enrollment period, the EUTF holds various informational sessions for employee-beneficiaries and dependent-beneficiaries. At its own cost, contractor shall provide staff and written informational materials for such informational sessions.

Contractor shall provide any other assistance as may be reasonably requested by the administrator in connection with any open enrollment period; provided that contractor shall not be required to incur any costs or expenses beyond that contemplated by its proposal or required under the contract.

9. Other Enrollment Assistance

From time to time, the EUTF may hold training sessions for its staff and/or other government personnel involved in EUTF operations, e.g., the public employers' departmental personnel officers. In addition, the EUTF holds informational meetings at various places around the State of Hawaii for its employee-beneficiaries and dependent beneficiaries, e.g., periodic pre-retirement and retirement informational meetings for employees, and informational meetings for employees facing a reduction in force. At its own cost, contractor shall provide staff and written informational materials for these training sessions and informational meetings.

Upon request and at no additional cost to the EUTF, contractor shall provide information to the EUTF necessary to update its eligibility and enrollment files, e.g., current addresses of employee-beneficiaries.

10. Coordination of Benefits/Medicare Claims

Contractor shall provide all services necessary to coordinate benefits ("COB") between its health benefits plans and other health benefit plans of the EUTF's employee-beneficiaries and dependent-beneficiaries. It will be the responsibility of the contractor to pursue 100% compliance with disclosure of COB information from participants. In addition, the contractor shall on behalf of the EUTF perform all services necessary to reconcile reimbursement claims made by Medicare to the EUTF or any public employer that arise with respect to contractor's health benefits plans.

11. Reports and Accountings

All reports that the contractor is required to give to the EUTF under the contract shall be in form and substance reasonably satisfactory to the EUTF. Upon reasonable advance notice, the EUTF may require changes in the form of the reports or may request that the reports contain different or additional information.

Contractor shall provide monthly operations reports to the EUTF. The monthly operations reports shall initially be in a letter format and each report shall be due on or before the 10th day of the month following the month that is the subject of the report. The monthly operations reports shall include information including, but not limited to, the following: (1) operational issues pertaining to EUTF members participating in the contractor's plans such as member mailings or network changes; (2) issues raised by or with the contractor and correspondence to or referred to the contractor; (3) publications or press releases relating to the contractor's plans that may be of interest to EUTF members; (4) community activities relating to the contractor that may be of interest to the EUTF members; (5) any legal actions or proceedings involving EUTF members; and (6) any complaints by EUTF members to the contractor or the Insurance Division relating to the contractor's plans.

Contractor shall provide monthly reports on financial operations in hard copy and electronically. The monthly financial reports shall be due on or before the 10th day of the month following the month that is the subject of the report.

Contractor shall provide quarterly reports on performance standards and performance guarantees in hard copy and electronically. The quarterly reports shall be due on or before the 30th day following the end of the quarter that is the subject of the report. Contractor shall also provide quarterly financial reports by bargaining unit.

Contractor shall provide an annual plan performance report with the incurred and paid accounting report within 120 days after June 30 of each plan year as well as any recommendations to improve the plan design or plan administration. The report shall be provided in hard copy and electronically. There shall be two (2) separate reports, one for actives and one for retirees. The active report should also contain a report by bargaining unit. The retiree report shall be split between Medicare and non-Medicare retirees.

Upon request, contractor shall provide to the EUTF a report containing information on all claims received and/or processed by contractor during a specified period of time. Such a report shall be provided on a hard copy and diskette or CD.

Upon reasonable advance notice, the EUTF may request special reports on matters pertaining to contractor's benefit plans and/or contractor's performance of the contract.

12. Privacy, Confidentiality and Security of Information

Contractor shall protect all information, records, and data collected in connection with this contract from unauthorized disclosures. The EUTF and contractor shall determine if and when any other party may have authorized access to such information.

Contractor shall guard the privacy, confidentiality and security of participant information. Access to participant information shall be limited by contractor to persons or agencies that require the information in order to perform their duties in accordance with the contract. Any other party shall be granted access to confidential information only after compliance with the requirements of all federal, state, and county laws pertaining to such access, e.g., HIPAA.

Contractor is required to know and understand all privacy, confidentiality and information security laws that pertain to its benefit plan and its performance of the contract. This includes knowledge and understanding of laws specific to certain groups (i.e., HRS chapter 577A relating to minor females and pregnancy and family planning services, HRS §325-101 relating to persons with HIV/AIDS, HRS §334-5 relating to persons receiving mental health services, and 42 CFR Part 2 relating to persons receiving substance abuse services).

Nothing in this section shall prohibit the contractor from disclosing information to the EUTF or its designee.

13. Electronic Data Transmissions

Contractor shall have hardware, software, and systems that are capable of picking up or receiving electronic data transmission from the EUTF regarding enrollments, changes to enrollments, premiums, and other matters related to the contract.

Contractor shall accept the EUTF's HIPAA-compliant, semi-monthly electronic data transmissions as the official membership eligibility/enrollment records, subject to adjustments as authorized by the EUTF.

14. Payment to Contractor

Payment to contractor will be done in arrears, after the month is completed. Such payments shall be made by the 15th day of the following month. If the 15th day of the month falls on a weekend or holiday, the payment will be made on the next succeeding weekday that is not a holiday.

For purposes of calculating the amount of premiums or fees due the contractor, the number of employee-beneficiaries enrolled in contractor's plans shall be determined as of a given date of the month, to be selected by the EUTF. Retroactive additions and terminations shall be accounted for in future payments.

Contractor shall accept the monthly summary enrollment reports provided by the EUTF as the basis for the amount of premiums due the contractor under the contract. Contractor shall notify the EUTF in writing within ninety (90) calendar days after the end of the report month of any transaction or premium computation discrepancy or other problem in the monthly summary report. The contractor shall provide specific information that is necessary to resolve any noted discrepancy or problem. If the EUTF is not notified in writing within the ninety (90) days, the EUTF reports shall be considered as final and accepted by the contractor.

15. Optional Extension Periods

At its sole discretion, the EUTF shall have: (a) two separate options to extend the contract for additional one (1) year terms; and (b) one option to extend the contract for an additional two (2) year term. The EUTF may exercise the first option for a one-year extension or the option for a two-year extension by giving written notice to the contractor at least sixty (60) calendar days prior to the expiration of the initial term of the contract. The EUTF may exercise the second option for a one-year extension by giving written notice to the contractor at least sixty (60) calendar days prior to expiration of the first one-year extension of the contract.

The premiums for any optional extension periods shall be negotiated based on the following formula:

[12-month claim base adjusted by trend rate] + [retention] subject to contractor's rate cap

Contractors that do not use experience rating (such as community rating with rate adjustment factors) should use the alternative that was proposed in their proposal as accepted by the EUTF and/or required in the contract.

To the extent that rates, premiums, or other matters negotiated under the contract are subject to federal or state regulation or approval, the contractor shall follow such regulations and obtain such approvals. In the event that changes or adjustments to rates, premiums, or other matters are required to comply with federal or state regulation or to obtain federal or state approvals, the contractor shall make such changes or adjustments; provided, however, that if the changes or adjustments increase rates or premiums to the EUTF, the EUTF shall have the option of renegotiating the rates, premiums and award of contract, canceling the award of contract, or terminating the contract.

16. Health Benefit Plan Tiering Structure

This RFP requests rates on a three-tier basis (single, two party and family).

17. Retrospective Payment Agreement/Minimum Premium Plan/Flexible Funding

If agreed to by contractor, the contract for an insured plan may include a retrospective premium agreement equal to 5% or 10% of the contractual premium.

Under a 5% retrospective premium agreement, the premiums actually paid to contractor for each month of the contract will be ninety-five percent (95%) of the premiums due for that month. If the annual accounting reveals that claims and retention exceed ninety-five percent (95%) of the premiums due for the plan year that is the subject of the accounting, the EUTF will pay contractor the amount of that excess up to the withheld five percent (5%). However, in no event shall the EUTF be liable under the contract for any excess amounts that exceed the withheld five percent (5%).

Alternatively, if agreed to by contractor, the contract for an insured plan may be on a minimum premium basis. Under a minimum premium plan, the EUTF will pay the contractor for administrative expenses (aka

retention) each month and will also pay for paid claims periodically up to a certain maximum amount as agreed upon between the contractor and the EUTF.

18. Experience Rating

Provision of health benefit plan services is to begin October 1, 2009

If, in the initial term of the contract (October 1, 2009 through June 30, 2011), earned premium under an insured plan exceeds total charges (net incurred and paid claims plus retention and the incurred reserve), the surplus will be held in a rate stabilization reserve ("RSR") or, at the option of the EUTF, the entire surplus will be refunded to the EUTF for each specific plan year at the time of the annual accounting. Should a deficit result in the initial term of the contract, the contractor may carry the deficit forward and reduce any surplus from any extension years. Accounting will be separate for active employees and retirees; the surplus of one group will not be used to offset the deficit of the other. Upon termination of the contract or expiration of the contract term: (1) any surpluses will be returned to the EUTF, and (2) the EUTF will not be liable for any deficits. Interest using the current 6-month T-Bill rate will be paid on reserves held either in an RSR or being returned to the EUTF beginning 120 days after the plan year until the date the surplus is returned to the EUTF.

19. Performance Standards And Guarantees

All contracts will include the following performance standards:

Respond to 95% of written inquires within 20 calendar days
Resolve 95% of written inquires within 30 business days
Resolve 95% of telephone inquires within 1 calendar day
Maintain an Average Speed of Answer of 30 seconds or less
Maintain call abandonment rate below 5%
Respond to 95% of Trustee, Administrator and Professional inquires within 10 calendar days
Process 99% of appeals within 60 calendar days
Process 99% of claims within 30 calendar days
Achieve 99% Financial Accuracy
Achieve 95% Coding Accuracy

Health benefit contracts also will include the following performance standards:

Achieve a minimum of 90% satisfaction on annual surveys
Issue 100% of ID cards within 15 calendar days
Maintain network turnover below 5%

The intent of the performance standards is to measure response time, not resolution time, but inquiries that are resolved at the initial point of contact should be included in both the numerator and denominator when calculating percentages. The standard for Professional inquiries refers to inquiries from the Attorney General's office, the Consultant or any other professional hired by the EUTF. The standard related to appeals refers to employee-beneficiary appeals, not provider appeals.

The contract will contain the following performance guarantees:

Guarantee	Penalty	How Measured	Frequency
Achieve a minimum of 99% financial accuracy.	1% of Quarterly Premium	Self-reported, based on internal quality review audits; verified periodically by outside audits. [Dollars Paid – overpayments – underpayments] divided by [Dollars Paid].	Quarterly
Process 99% of claims within 30 calendar days.	1% of Quarterly Premium	Self-reported, based on system reports; verified periodically by outside audits	Quarterly
Answer 90% of calls within 30 seconds	1% of Annual Premium	Operations reports	Annual

Any penalty will be tripled if it is the result of an audit that finds erroneous self-reporting of meeting a standard. Results should be reported rounded to the nearest percentage point; for example, 89.6% should be reported as 90%.

These standards and guarantees shall apply unless the contractor specifically submits and the EUTF accepts a counter proposal.

20. HIPAA (Health Benefit Contractor Obligations)

With respect to all information and transactions related to or that arise out of the contract or contractor's performance of the contract, contractor shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the rules passed thereunder, including those dealing with privacy, security, and electronic transactions (collectively "HIPAA").

At no additional cost to the EUTF, the contractor shall assist the EUTF in meeting any requirements or performing any obligations that the EUTF is obliged to meet or perform under HIPAA. This includes but is not limited to: (1) providing access to protected health information ("PHI") in accordance with 45 C.F.R. §164.524; (2) making PHI available for amendment in accordance with 45 C.F.R. §164.526; (3) providing information necessary for the EUTF to respond to a request for an accounting in accordance with 45 C.F.R. §164.528; and (4) making contractor's practices, books, and records available to the Secretary of Health and Human Services as required to determine the EUTF's compliance with HIPAA. PHI shall have the meaning set forth in 45 C.F.R. §164.501.

At no additional cost to the EUTF, contractor shall provide the services specified below with respect to the issuance of certificates of creditable coverage as required by HIPAA. The contractor shall:

a) Prepare and mail a certificate of creditable coverage:

   i) When a plan member (including a covered dependent) has incurred a loss of coverage and is entitled to elect COBRA continuation coverage under the plan;

   ii) When a plan member (including a covered dependent) who has elected COBRA continuation coverage has terminated such coverage;

   iii) Upon receipt of a request from a plan member (including a covered dependent), or upon notice from the EUTF that the plan member has requested the EUTF to provide a certificate, if the plan member's request was made within 24 months after a loss of coverage was incurred.

b) Maintain copies of certificates of creditable coverage issued to plan members for a period of not less than two years.

c) Answer inquiries from plan members relating to certificates of creditable coverage.

21. COBRA and USERRA (Health Benefit Contractor Obligations)

Health benefit contractors shall assist the EUTF in meeting its responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

The EUTF will distribute the general COBRA notices at the time of eligibility and send COBRA notices at the time of a qualifying event. The contractor shall administer COBRA for anyone who elects COBRA continuation coverage.

At no additional cost to the EUTF, the contractor shall provide the following services. The contractor shall:

a) Directly bill and collect premiums including any applicable service charges from individuals;

b) Maintain eligibility information and reconcile individual accounts;

c) Distribute and process COBRA notices other than the general and election notices when required;

d) Answer inquiries from former employee-beneficiaries and dependent-beneficiaries who continue plan coverage under COBRA or USERRA provisions and handle subsequent open enrollments for such persons;

e) Prepare reports for the EUTF on COBRA and USERRA cases.

22. QMCSOs (Health Benefit Contractor Obligations)

At no additional cost to the EUTF, health benefit contractors shall assist the EUTF in meeting its obligations with respect to Qualified Medical Child Support Orders ("QMCSOs") and shall provide the following services:

a) Mail benefit checks to the alternate recipient or designated custodial parent or court appointed guardian when required under the terms of the Plan and the QMCSOs.

b) Answer inquiries from alternate recipients or designated court-appointed guardians who receive benefits under the Plan.

23. Patient Billing (Health Benefit Contractor Obligations)

Health benefit contractors shall ensure that no contracted provider in its

network bills EUTF employee-beneficiaries or dependent-beneficiaries for more than the stipulated deductible or coinsurance portion of the allowable fee for a service.

24. Everson Lawsuit

The EUTF reserves the right to renegotiate any and all awards of contract and/or contracts resulting from this RFP if necessary to comply with any orders or judgments entered in the following pending lawsuit and appeal (and any proceedings related thereto): Marion Everson, et al. v. State of Hawaii, et al., Civil No. 06-1-1141-06 BIA, Circuit Court of the First Circuit, State of Hawaii, and Marion Everson, et al. v. State of Hawaii, et al., Appeal No. 29359, Intermediate Court of Appeals, State of Hawaii (an appeal from Civil No. 07-1-1872, Circuit Court of First Circuit, State of Hawaii) . In the lawsuit and appeal, certain retirees claim that the EUTF is required by the Hawaii Constitution and/or other Hawaii law to provide retirees and their dependent-beneficiaries with health benefits that are the same or reasonable approximate to those provided to active employees and their dependent-beneficiaries.

25. Ascend Specialty Pharmacy – Exclusive Provider
The EUTF has approved a change in its health benefits plans, effective July 1, 2009, that consists of moving the specialty medications exclusively to Ascend SpecialtyRx for active employees, non-Medicare retirees, and their dependent-beneficiaries enrolled in the self funded medical PPO plans.

All of the following forms of specialty drugs will be processed and dispensed through Ascend SpecialtyRx Pharmacy as the exclusive provider of benefits for the EUTF:

a. Orals
b. Inhaled
c. Self Administered Non-Oncology Injectables (SQ/IM)

All current participants that are utilizing these forms of specialty medications under the medical benefit will be transitioned over to Ascend Specialty Pharmacy effective 7/1/09.

Specialty Drug list is provided in Appendix O.

PREMIUM PROPOSAL

As the term of the contract is expected to be 21 months with possible extensions (granted only at the discretion of the EUTF), the Premium Proposal should be presented on the Rate Proposal Forms provided in Appendix E. The offeror shall provide premium rates for the benefit plan designs provided in Appendix N. The offeror may also provide premium rates for one or more benefit plan designs that are different than those described in Appendix N. The services detailed under Paragraph V of the Scope of Work Section of this RFP should form the basis for the proposed fees and should be referred to for a detailed description of the services required of the successful offeror. Proposed fees must be all-inclusive, i.e., must include all of the offeror's compensation, travel, taxes, costs and expenses.

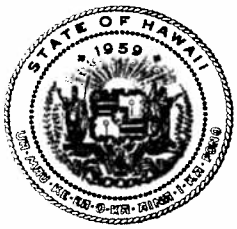
The method of payment is described in Paragraph 14, Scope of Services of the Scope of Work section.

The final contract premiums should represent the only compensation received by the offeror for services provided to the EUTF. There should not be any other benefit, monetary or otherwise, that results from this relationship between the offeror and the EUTF.

APPENDICES

APPENDIX A:	HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ANNUAL REPORT
APPENDIX B:	EUTF FINANCIAL STATEMENTS
APPENDIX C:	CONTRACT AND GENERAL CONDITIONS
APPENDIX D:	QUESTIONS FOR OFFERORS (ALSO AVAILABLE ELECTRONICALLY)
APPENDIX E:	RATE PROPOSAL FORMS
APPENDIX F:	OFFER FORM OF-1
APPENDIX G:	WAGE CERTIFICATION
APPENDIX H:	AON RISK SERVICES, INC OF HAWAII ANNUAL REPORT
APPENDIX I:	UTILIZATION REPORTS
APPENDIX J:	CENSUS DATA
APPENDIX K:	CHAPTER 87A (HRS)
APPENDIX L:	ADMINISTRATIVE RULES
APPENDIX M:	EUTF REFERENCE GUIDES
APPENDIX N:	PROPOSED PLAN BENEFIT DESIGNS
APPENDIX O:	ASCEND SPECIALTY PHARMACY – EXCLUSIVE PROVIDER

Appendix A
Hawaii Employer-Union Health Benefits Trust Fund Annual Report



ANNUAL REPORT

FISCAL YEAR 2007-08

Hawaii Employer-Union Health Benefits Trust Fund
State of Hawaii

December 2008

This report presents an overview of the activities of the Hawaii Employer-Union Health Benefits Trust Fund ("EUTF") for the fiscal year 2007 - 2008. The EUTF is administratively attached to the Department of Budget and Finance. The EUTF's office is located at Suite 1520, City Financial Tower, Honolulu, Hawaii.

OVERVIEW

Chapter 87A of the Hawaii Revised Statutes established a trust fund known as the Hawaii Employer-Union Health Benefits Trust Fund. The EUTF is the state agency that provides eligible state and county employees and retirees and their eligible dependents with health and life insurance benefits. The EUTF replaced the Hawaii Public Employees Health Fund ("PEHF"), effective July 1, 2003.

TRUST FUND ORGANIZATION

Board of Trustees

The EUTF is administered by a board of trustees ("Board"). The Board is responsible for determining the nature and scope of the benefit plans offered, negotiating and entering into contracts with insurance carriers and plan administrators, establishing eligibility criteria and management policies for the EUTF, and overseeing all EUTF activities.

There are ten trustees, five representing the public employers and five representing employee-beneficiaries, including a retiree representative. The current trustees are shown below:

Employer Trustees
- Barbara Annis
- Darwin Ching
- Marie Laderta
- Lawrence Reifurth
- Stanley Shiraki

Employee-Beneficiary Trustees
- Carl Daeufer, Retirees
- Guy Fujio, HFFA
- Elizabeth Ho, AFSCME
- George Kahoohanohano, SHOPO
- John Radcliffe, UHPA

Board officers currently are Marie Laderta, Chairperson, Barbara Annis, Vice-Chairperson and Elizabeth Ho, Secretary-Treasurer. The officers serve a one-year term beginning July 1 of each year.

During the period covered by this report, the Board has used both standing and temporary committees to facilitate its administration of the EUTF. The two standing committees are the Administrative Committee and the Benefits Committee. The Administrative Committee considers matters pertaining to the administration and operation of the EUTF, e.g., development of budget, organization of staff, setting of personnel policies, evaluation of EUTF systems, and consideration of use of third party administration services. The Benefits Committee considers matters pertaining to the design and procurement of the EUTF's health and life insurance benefit plans.

Administrator and Staff

The day-to-day administration of the EUTF is managed by an administrator who reports to and is responsible to the Board. The administrator is James Williams who was hired in November 2004. The EUTF administrator and new staff positions are exempt from civil service.

The administrator is assisted in managing the EUTF by an assistant administrator, a financial management officer, and an information systems analyst. EUTF staff has a total of 35 employees (including management staff and the Administrator).

The EUTF has three branches: the Financial Services Branch, Information Systems Branch, and Member Services Branch. A health benefits program manager oversees the Member Services Branch and is supported by employees assigned to customer service duties that include answering phones and e-mails from members and handling all processing for retirees and the other employees process all active employee enrollment submissions. The financial management officer is supported by two accountants and three account clerks, who reconcile employee accounts, collect employer/employee contributions for health benefits and process all payments. The EUTF information systems analyst provides internal IT support services, fulfills HIPAA security responsibilities, coordinates additional support services provided by DAGS/ICSD, is the project manager for the new benefits administration system implementation (BAS) project and is supported by one IS specialist.

Advisors and Consultants

The Board utilized the services of Aon Consulting as its benefits plan consultant effective June 28, 2007. A request for proposal for benefit plan consulting services was issued in March 2007 and the contract was awarded to Aon Consulting in June 2007 with an effective contract start date of June 28, 2007. Aon Consulting is among the top global human capital and management consulting firms, providing a complete array of consulting, outsourcing and insurance brokerage services. The Honolulu office staffed by 11 consultants and support staff focuses on the delivery of employee benefit programs consistent with Hawaii statutes. Aon's contract is through June 30, 2009 with an option to extend the Contract for two years from July 1, 2009 through June 30, 2011.

The Board also has employed professional consultants and advisors on certain specific issues of importance to the EUTF. Business Solutions Technologies (BST) was retained to assist the EUTF with on-going support of the PeopleSoft health fund information management system (PeopleSoft/HFIMS) and assist as technical subject matter experts for implementing the new BAS. Vitech Systems Group, Inc. was selected to implement a new benefits administration system. This system will replace the PeopleSoft/HFIMS. Gartner, Inc. is providing project oversight and assessment over the implementation of the new benefits administration system. In addition, an advisor seat was purchased from Gartner, Inc which offers a cost-effective way for EUTF to obtain valuable technical research, information and reports to support critical information technology needs. .

ADMINISTRATIVE RULES

The EUTF operates according to administrative rules originally adopted in February 2003. The administrative rules were formulated to meet the requirements of Chapter 87A, Hawaii Revised Statutes, and the health and other benefit plans established by the EUTF. In addition, they were designed to increase administrative efficiencies and reduce the EUTF's administrative costs. For example, the rules set the effective dates for initial enrollments, changes in enrollment, and cancellations of enrollment in the EUTF's health benefit plans so as to facilitate automated handling of such activities. After a general review by the staff and Board, the administrative rules were revised in December 2007.

HEALTH AND LIFE INSURANCE BENEFIT PLANS

During fiscal year 2007-2008, the EUTF provided health and life insurance benefits through contracts with the following organizations:

- Hawaii Medical Service Association (HMSA)
- Health Management Associates (HMA)
- Kaiser Permanente (Kaiser)
- National Medical Health Card Systems, Inc (NMHC)
- Hawaii Dental Service (HDS)
- Vision Service Plan (VSP)
- Royal State National Insurance Company, Ltd./ChiroPlan Hawaii, Inc. (ChiroPlan)
- Royal State National Insurance Company, Ltd. (Royal State)
- Standard Insurance Company (Standard)

During fiscal year 2007-2008 the EUTF introduced several new medical plan options for both employees and retirees. HMSA and HMA provided Preferred Provider Option (PPO) plans for both employees and retirees. The Kaiser Comprehensive Option HMO plan remained available for both employees and retirees. Two additional HMO medical plans were added for active employees, a Kaiser Basic Option HMO medical plan and an HMSA HMO medical plan. A new plan, the HMSA High Deductible Health Plan, was introduced for active employees. The supplemental plans offered by HMSA and Royal State National remained the same. HDS and VSP provided the regular dental and vision plans respectively for active employees and the regular dental and vision plans for retirees. The supplemental plans for both dental (HDS) and vision (VSP) were dropped due to lack of participation. Standard Life Insurance won the contract for the insurance plan, replacing Aetna, for active employees and retirees. Contracts with these organizations expire on June 30, 2009.

For both active employees and retirees, the health benefit plans provided by the EUTF during the fiscal year were available to domestic partners and full-time students up to the age of 24. No additional premium was required for student coverage under the family option. Active employees also received chiropractic benefits through ChiroPlan Hawaii which was offered in combination with any of the medical plans offered.

All active employees who have medical coverage through private sector or federal government plans were eligible to enroll in either of two Supplemental Medical Plans. The Royal State National Insurance Company, Ltd offered a dual coverage medical reimbursement plan, and HMSA offered a fee-for-service dual coverage plan.

The table below shows active employees' enrollment as of June 30, 2008.

Type of Benefit Plans	Type of Coverage			Grand Total
MEDICAL - Self Funded	**Self**	**Two-Party**	**Family**	
PPO				
Health Management Associates	308	94	134	536
Hawaii Medical Service Association	17,081	5,204	9,952	32,237
High Deductible Health Plan (HDHP)				
Hawaii Medical Service Association	71	12	16	99
Supplemental				
Hawaii Medical Service Association	268	160	277	705
Royal State National	111	118	249	478
HMO				
Hawaii Medical Service Association	766	269	377	1,412
MEDICAL - Fully Insured				
Kaiser Comprehensive	4,591	1,457	2,348	8,396
Kaiser Basic	131	40	48	219
Total Enrolled				44,082
Waived				10,600
TOTAL MEDICAL				54,683
PRESCRIPTION DRUGS - Self Funded				
National Medical Health Card				
Prescription Drug Only	52	41	58	151
With PPO Plans	17,389	5,298	10,086	32,773
With Dual Plans	268	160	277	705
TOTAL PRESCRIPTION DRUGS				33,629
DENTAL				
Hawaii Dental Service	21,696	9,054	15,637	46,387
Waived				8,286
TOTAL DENTAL				54,673
VISION				
Vision Services Plan	21,562	8,131	14,319	44,012
Waived				10,684
TOTAL VISION				54,696
LIFE INSURANCE				
Standard Life Insurance				54,636
Waived				197
TOTAL LIFE INSURANCE				54,833

The table below shows retirees' enrollment as of June 30, 2008

Type of Benefit Plans	Type of Coverage			
MEDICAL - Self Funded	**Self**	**Two-Party**	**Family**	**Grand Total**
PPO				
HMA Non-Medicare	1	9	2	12
HMA With Medicare	5	7	0	12
HMSA Non-Medicare	3,066	3,414	1,062	7,542
HMSA With Medicare	13,594	7,826	423	21,843
HMO				
Kaiser Non-Medicare	764	702	225	1,691
Kaiser With Medicare	3,188	1,543	111	4,842
Kaiser Out of State	89	54	1	144
Total Enrolled				36,086
Waived				802
TOTAL MEDICAL				36,888
PRESCRIPTION DRUGS - Self Funded				
National Medical Health Card				
Non-Medicare	3,067	3,423	1,064	7,554
Medicare Part D	13,549	7,772	422	21,743
Waived				104
TOTAL PRESCRIPTION DRUGS				29,401
DENTAL				
Hawaii Dental Service	20,612	13,399	1,715	35,726
Waived				1,161
TOTAL DENTAL				36,887
VISION				
Vision Services Plan	20,551	13,628	1,831	36,010
Waived				879
TOTAL VISION				36,889
LIFE INSURANCE				
Standard Life Insurance				31,994
Waived				76
TOTAL LIFE INSURANCE				32,070

OPERATIONS

During fiscal year 2007, the EUTF implemented several major policy and program changes as follows:

- Changed Prescription Drug carriers from HMSA to NMHC (July 1, 2007)
- Implemented four new Medical plans (two HMO, one PPO and one HDHP plans effective July 1, 2007)
- Implemented the EUTF self-funded health plans
- Selected ViTech's V3 BAS software to replace the PeopleSoft benefits administration system
- Dropped the supplemental (dual) dental and vision plans

These implementations challenged EUTF resources, staff capabilities and communications processes.

Ongoing Programs and General Operations

The EUTF participates with the major State departments and counties which host pre-retirement, orientation and other informational sessions during the year. Over 3,400 interested employees attended these sessions. The EUTF continued the program to provide on-site retirement counseling in conjunction with the Employee Retirement System's periodic group retirement counseling sessions. During these sessions, the employee receives counseling from the EUTF staff on their retirement health and life insurance benefits.

During FY2008, the EUTF Customer Service staff faced significant challenges that resulted from the programs noted above. From July 1, 2007 – June 30, 2008, the EUTF Customer Service line received over 53,433 incoming telephone calls. In addition, the Customer Service staff made 17,275 outgoing calls. To address the volume of calls, a new, more efficient automated call distribution system was implemented in March 2008. The results have been significant. During the first 8 ½ months of the fiscal year, the EUTF was able to answer less than 60% of all incoming calls. Since the implementation, the EUTF Customer service section has been able to answer over 93% of all incoming calls. This has provided the EUTF functionality to route calls more efficiently. The additional types of plans and the implementation of the Medicare Part D Prescription Drugs plan had a significant impact on the types of calls received by the EUTF. The number of outgoing calls increased significantly due to the complexity of the questions and inquiries fielded.

In addition, the same staff processed over 15,600 retiree enrollment-related forms, processed, printed and mailed over 6,800 COBRA election notices, 5350 COBRA initial notices, 3,000 COBRA related notices, 20,000 confirmation notices, 6,000 retiree related notices and other project notices or letters such as the special enrollment and responses to retiree requests.

The Enrollment staff received and imaged 56,437 documents during FY2008. Of the documents received and imaged, the staff processed all but 3,583 documents for a completion rate of 94% by July 2008. Enrollment related documents which affected an employee or retiree's benefit plans or coverage total nearly 73% of all documents submitted. Other documents dealt with change of address, correction or clarification of data submitted, removal of dependents from plans and other miscellaneous categories.

The FY 2009 Open Enrollment for active employees was held from April 14, 2008 to May 14, 2008. The EUTF staff conducted 12 training sessions on the four major islands which were attended by over 350 personnel and financial officers. From April 14 – May 16, 2008, 43 open enrollment informational sessions for employees were held on the four major islands plus Molokai and Lanai. About 2,500 employees attended these sessions. Even with the minor changes from the previous year, the EUTF received and processed nearly 9,700 open enrollment changes from the active employees.

In order to better synchronize with the Medicare Part D open enrollment period held in November/December of each year, the open enrollment for EUTF retirees was not held in the spring of 2008 and will be held in fall 2008 to precede Medicare's open enrollment.

FISCAL YEAR 2008

During FY 2008, the EUTF collected $551,754,581,in employer and employee contributions for health benefit plans and paid carriers $511,378,717 in premiums. Medicare Part B reimbursements paid to retirees amounted to $40,948,023. The above amounts are presented on an accrual basis and do not include retrospective premium amounts of approximately $2.7 million due to HDS and VSP and incurred but not reported expenses in the amount of approximately $35.4 for the self-funded plans.

An annual audit of the EUTF, as required by Chapter 87A-25(2), was conducted for the plan year July 1, 2007 through June 30, 2008 by Grant Thornton LLP. This audit report includes Government Accounting Standards Board Statement No. 43 (GASB 43), Financial Reporting for Post-employment Benefit Plans Other Than Pension Plans. The EUTF financial reports as presented in the Audit Report were approved by the EUTF Board of Trustees on December 8, 2008 and are attached to and incorporated in this report.

Appendix B
EUTF Financial Statements

Hawaii Employer-Union Health Benefits Trust Fund
STATEMENT OF NET ASSETS
(Unaudited)

	March 31, 2009		June 30, 2008	
ASSETS				
CURRENT ASSETS				
Cash				
General	$ 84,845,485		$ 40,770,440	
Short-term investments	45,223,808	$ 130,069,293	49,271,063	$ 90,041,503
Petty Cash		150		150
Receivable from State of Hawaii and Counties		15,557,155		13,511,471
Other Receivable from Agencies		4,109		3,809
Receivable from Employee - beneficiaries, Net of Allowance for Bad Debt		25,798		64,972
Medicare reimbursements receivable from individuals, Net of Allowance for Bad Debt		154,574		16,484
Premium reserves held by insurance companies		400,000		61,347,441
Self funded reserves		19,400,000		19,400,000
Prepaid expenses		54,304		31,180
Due from State of Hawaii and counties		345,083		196,749
Total Current Assets		166,010,466		184,613,759
NONCURRENT ASSETS				
Capital Assets, Net of Accumulated Depreciation		191,963		242,832
Construction in Progress (Computer System)		3,324,122		3,324,122
Total Noncurrent Assets		3,516,085		3,566,954
Total Assets		$ 169,526,551		$ 188,180,713
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Vouchers and Contracts Payable		$ 107,487		$ 176,804
Accrued Salaries and Wages		129,272		111,378
Retainage Payable to Vitech		132,012		62,506
Retrospective premium payable		2,556,748		2,706,555
Payable to Insurance Carriers		12,412,076		12,056,723
Net OPEB Liability		167,151		167,151
Medicare Part B Premium Reimbursement Payable		-		-
Administration Fees Liability for Self-Funded Plans		2,034,353		1,929,743
Benefits Liability for Self-Funded Plans		33,959,971		25,078,462
IBNR Liability for Self-Funded Plans		39,227,000		35,389,000
Out-of-State Medical Payable		-		-
Compensated Absences, current portion		41,985		41,985
Total Current Liabilities		90,768,055		77,720,307
NONCURRENT LIABILITIES				
Compensated Absences		116,257		116,257
Total Liabilities		90,884,312		77,836,564
NET ASSETS				
Retained Earnings				
Invested in Capital Assets		3,516,085		3,566,954
OPEB Accumulation Fund		45,230,531		34,271,063
Unrestricted		29,895,623		72,506,132
Total Net Assets		78,642,239		110,344,149
Total Liabilities and Net Assets		$ 169,526,551		$ 188,180,713

Hawaii Employer-Union Health Benefits Trust Fund
COMBINED STATEMENT OF REVENUES AND EXPENSES -
BUDGET & ACTUAL COMPARISON
9 Months Ended March 31, 2009
(Unaudited)

	Annual Budget	3/31/2009 9-Month Budget	3/31/2009 9-Month Actual	Variance	3/31/2009 9-Month - Other	Self-Funded Plans 9-Month - Other	Notes
REVENUES							
Premium Revenue for Self-Funded Plans	$ -	$ -	$ -	$ -	$ -	$ 287,948,230	HMSA, NMHC and HMA Inc. self-funded plans.
Administrative Fee - EUTF	4,967,899	3,725,924	3,928,053	202,129	-	-	
Interest Income	1,459,812	1,933,895	1,933,895	-	-	-	
OPEB Employer Contribution	-	-	-	-	10,352,077	-	$948,077 (Hawaii Cty DWS), $1,200,000 (C&C BWS), $7,500,000 (Hawaii Cty), & $704,000 (Kauai Dept. of Water)
Increase in Reserves (Gains)	-	-	-	-	395,742	-	$7,104 (vacation credits transferred in with new employees), $66,820 (Kaiser medicare low income subsidy), and $321,818 (HMSA FY09 interest on FY07 gains)
NMHC Rebate	-	-	-	-	-	5,126,293	NMHC Prescription Drug Rebates
IBNR Benefits Reduction	-	-	-	-	-	-	
Purchasing Card Rebates	-	-	-	-	381	-	
Total operating revenues	6,427,711	5,659,819	5,861,948	202,129	10,748,200	293,074,523	
EXPENSES							
TPA Expenses	-	-	-	-	-	19,225,827	
Benefits Paid for Self-Funded Plans	-	-	-	-	-	313,679,916	
IBNR Benefits for Self-Funded Plans	-	-	-	-	-	3,838,000	IBNR adjustment as of 12/31/08 approved by Board of Trustees.
Personal Services	1,937,256	1,452,942	1,266,465	186,477	-	-	Overtime Salaries is $890 for this 9-month period. EUTF currently has 7 vacancies.
Office Supplies	14,000	10,500	7,262	3,238	-	-	
Dues & Subscriptions	1,300	975	1,055	(80)	-	-	
Postage	73,000	56,750	46,426	10,324	-	-	
Telephone & Telegraph	24,000	18,000	18,285	(285)	-	-	
Printing & Binding	125,000	86,000	97,516	(11,516)	-	-	EUTF Newsletter & Retiree OE. Retiree OE postage was higher than budgeted.
Advertising	-	-	497	(497)	-	-	
Car Mileage	650	488	289	199	-	-	
Transportation - Intra State	19,800	13,800	6,505	7,295	-	-	
Transportation - Out of State	32,960	26,780	12,299	14,481	-	-	
Office Space	290,000	217,500	203,724	13,776	-	-	
Rental of Equipment (Copier)	20,000	15,000	10,024	4,976	-	-	
R&M EDP	28,000	-	-	-	-	-	
Insurance	85,000	63,750	58,332	5,418	-	-	Amortization of Fiduciary Liability, Directors & Officers Coverage and Crime Coverage. In December 2008, renewal of insurance in the amount of $81,455.68.
Services On A Fee Basis (AG Salary)	88,500	66,375	-	66,375			AG office has not billed EUTF since August 2007.
Consultant Services	1,010,000	400,000	381,260	18,740	-	-	$89,845 (Gartner Group), $150,000 (AON Risk Services), $22,000 (AON Risk Services - Open Enrollment booklet), $94,749 (State Office of the Auditor - audit services performed by Grant Thornton) & $24,666 (Mercer Investment Consulting).
Training and Registration	18,480	15,285	10,960	4,325	-	-	IFEBP Annual Conference and Women's Conference
Computer System - Maintenance	793,953	689,568	252,626	436,942	-	-	$11,746 for Gartner Advisory Seat, $175 for Ipswitch software, $11,948 for Oracle licenses & support, $6,414 for IBM Filenet maintenance, $191,762 for BST, $14,677 for EOH Enterprises telephone system additional ports, $12,996 for ICSD Consolidated Server maintenance, & $2,908 for KH Electric. Encumbered $436,568 for BST contract in FY09.
New Benefits System	200,000	200,000	1,390,110	(1,190,110)	-	-	Vitech System Implementation - This item was encumbered in FY08 in DAGS FAMIS, therefore, EUTF will go over budget in FY09.
Other	-	-	-	-	-	-	
Equipment (New Benefits System) (Vitech)	-	-	332,900	(332,900)	-	-	Vitech System Equipment - This item was encumbered in FY08 in DAGS FAMIS, therefore, EUTF will go over budget in FY09.
Depreciation	-	-	-	-	50,869	-	
(Gain)/Loss from Carrier Payments	-	-	-	-	495,434	-	This amount is the resulting shortfall after the collection of employer/employee contributions and the payment to carriers. This amount fluctuates every month.
Total operating expenses	4,761,899	3,333,713	4,096,535	(762,823)	546,303	336,743,743	
EXCESS OF REVENUES OVER EXPENDITURES (LOSS)	$ 1,665,812	2,326,107	$ 1,765,413	$ (560,694)	10,201,897	$ (43,669,220)	

Hawaii Employer-Union Health Benefits Trust Fund
STATEMENT OF CASH FLOWS
9 Months Ended March 31, 2009
(Unaudited)

	T-903 Administrative	T-904 Operations	T-905 S-T Investments	Total
CASH FLOWS FROM OPERATING ACTIVITIES:				
Increases:				
Contributions Collected	$ -	$ 434,993,879	$ -	$ 434,993,879
OPEB Employer Contributions Collected	-	-	10,352,077	10,352,077
Return of Medicare Part B prem. reimb.	-	117,600	-	117,600
Interest income received	149,675	1,035,217	600,668	1,785,560
Transfer from/to Operations Account (T-904/905)	2,500,000	15,000,000	-	17,500,000
Cancelled warrants	2,423	-	-	2,423
FY 2007 gains/final accounting	-	61,321,666	-	61,321,666
Transfer of vacation credits from another agency	7,104	-	-	7,104
NMHC Rebate	-	5,126,293	-	5,126,293
Purchasing (P) Card Rebate	381	-	-	381
Other	892	289	-	1,181
TOTAL INCREASE IN CASH	2,660,475	517,594,944	10,952,745	531,208,164
Decreases:				
Payment to carriers	-	434,939,856	-	434,939,856
Medicare Part B prem. reimb.	-	32,219,743	-	32,219,743
Refund to employees / forfeitures	-	99,908	-	99,908
Employee returned checks	-	-	-	-
Return of retrospective amount to HDS/HMSA	-	2,315,978	-	2,315,978
Personal services - payroll	1,248,570	-	-	1,248,570
Transfer to Administrative Account (T-903)	-	2,500,000	-	2,500,000
Transfer to/from S-T Investment Account (T-904/905)	-	-	15,000,000	15,000,000
Transfer of vacation credits to another agency	-	-	-	-
Payment for administrative expenses	2,856,319	-	-	2,856,319
Other	-	-	-	-
TOTAL DECREASE IN CASH	4,104,889	472,075,485	15,000,000	491,180,374
NET INCREASE (DECREASE) IN CASH	(1,444,414)	45,519,459	(4,047,255)	40,027,790
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	8,632,501	32,137,939	49,271,063	90,041,503
TO-DATE CASH AND CASH EQUIVALENTS	$ 7,188,087	$ 77,657,398	$ 45,223,808	$ 130,069,293

Appendix C
Contract and General Conditions

STATE OF HAWAII

CONTRACT FOR GOODS OR SERVICES BASED UPON COMPETITIVE SEALED PROPOSALS

This Contract, executed on the respective dates indicated below, is effective as of _____, _____, between _____,
(Insert name of state department, agency, board or commission)
State of Hawaii ("STATE"), by its _____,
(Insert title of person signing for State)
(hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")), whose address is _____
_____ and _____
("CONTRACTOR"), a _____
(Insert corporation, partnership, joint venture, sole proprietorship, or other legal form of the Contractor)
under the laws of the State of _____, whose business address and federal and state taxpayer identification numbers are as follows: _____
_____

RECITALS

A. The STATE desires to retain and engage the CONTRACTOR to provide the goods or services, or both, described in this Contract and its attachments, and the CONTRACTOR is agreeable to providing said goods or services or both.

B. The STATE has issued a request for competitive sealed proposals, and has received and reviewed proposals submitted in response to the request.

C. The solicitation for proposals and the selection of the CONTRACTOR were made in accordance with section 103D-303, Hawaii Revised Statutes ("HRS"), Hawaii Administrative Rules, Title 3, Department of Accounting and General Services, Subtitle 11 ("HAR"), Chapter 122, Subchapter 6, and applicable procedures established by the appropriate Chief Procurement Officer ("CPO").

D. The CONTRACTOR has been identified as the responsible and responsive offeror whose proposal is the most advantageous for the STATE, taking into consideration price and the evaluation factors set forth in the request.

E. Pursuant to _____, the STATE
(Legal authority to enter into this Contract)
is authorized to enter into this Contract.

F. Money is available to fund this Contract pursuant to:

(1) _____
(Identify state sources)
or (2) _____
(Identify federal sources)
or both, in the following amounts: State $ _____
Federal $ _____

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the CONTRACTOR agree as follows:

1. Scope of Services. The CONTRACTOR shall, in a proper and satisfactory manner as determined by the STATE, provide all the goods or services, or both, set forth in the request for competitive sealed proposals number _____ ("RFP") and the CONTRACTOR'S accepted proposal ("Proposal"), both of which, even if not physically attached to this Contract, are made a part of this Contract.

2. Compensation. The CONTRACTOR shall be compensated for goods supplied

or services performed, or both, under this Contract in a total amount not to exceed _____ DOLLARS ($_____), including approved costs incurred and taxes, at the time and in the manner set forth in the RFP and CONTRACTOR'S Proposal.

3. Time of Performance. The services or goods required of the CONTRACTOR under this Contract shall be performed and completed in accordance with the Time of Performance set forth in Attachment-S3, which is made a part of this Contract.

4. Bonds. The CONTRACTOR ☐ is required to provide or ☐ is not required to provide: ☐ a performance bond, ☐ a payment bond, ☐ a performance and payment bond in the amount of _____ DOLLARS ($_____).

5. Standards of Conduct Declaration. The Standards of Conduct Declaration of the CONTRACTOR is attached to and made a part of this Contract.

6. Other Terms and Conditions. The General Conditions and any Special Conditions are attached to and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. In the event of a conflict among the documents, the order of precedence shall be as follows: (1) this Contract, including all attachments and addenda; (2) the RFP, including all attachments and addenda; and (3) the Proposal.

7. Liquidated Damages. Liquidated damages shall be assessed in the amount of _____ DOLLARS ($_____) per day, in accordance with the terms of paragraph 9 of the General Conditions.

8. Notices. Any written notice required to be given by a party to this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid. Notice to the STATE shall be sent to the HOPA'S address indicated in the Contract. Notice to the CONTRACTOR shall be sent to the CONTRACTOR'S address indicated in the Contract. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The CONTRACTOR is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures, on the dates below, to be effective as of the date first above written.

STATE

_____
(Signature)

_____
(Print Name)

_____
(Print Title)

_____
(Date)

CONTRACTOR

CORPORATE SEAL
(If available)

_____
(Name of Contractor)

_____
(Signature)

_____
(Print Name)

_____ *
(Print Title)

_____
(Date)

APPROVED AS TO FORM:

_____
Deputy Attorney General

* Evidence of authority of the CONTRACTOR'S representative to sign this Contract for the CONTRACTOR must be attached.

STATE OF HAWAII

CONTRACTOR'S ACKNOWLEDGMENT

STATE OF _____)
) **SS.**
_____ **COUNTY OF** _____)

On this _____ day of _____, _____ before me appeared _____ and _____, to me known, to be the person(s) described in and, who, being by me duly sworn, did say that he/she/they is/are _____ and _____ of _____, the CONTRACTOR named in the foregoing instrument, and that he/she/they is/are authorized to sign said instrument on behalf of the CONTRACTOR, and acknowledges that he/she/they executed said instrument as the free act and deed of the CONTRACTOR.

(Notary Stamp or Seal)

_____
(Signature)

_____
(Print Name)

Notary Public, State of _____

My commission expires: _____

Doc. Date: _____ # Pages: _____

Notary Name: _____ _____ Circuit

Doc. Description: _____

_____

_____

_____
Notary Signature Date

NOTARY CERTIFICATION

STATE OF HAWAII

CONTRACTOR'S STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, CONTRACTOR, the undersigned does declare as follows:

1. CONTRACTOR ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. CONTRACTOR has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. CONTRACTOR has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. CONTRACTOR has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

CONTRACTOR understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

* Reminder to Agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract must be awarded by competitive sealed bidding under section 103D-302, HRS, or a competitive sealed proposal under section 103D-303, HRS. Otherwise, the Agency may not award the Contract unless it posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

CONTRACTOR

By _____
(Signature)

Print Name _____

Print Title _____

Name of Contractor _____

_____

Date _____

STATE OF HAWAII

SCOPE OF SERVICES

STATE OF HAWAII

COMPENSATION AND PAYMENT SCHEDULE

STATE OF HAWAII

TIME OF PERFORMANCE

STATE OF HAWAII

CERTIFICATE OF EXEMPTION FROM CIVIL SERVICE

1. By Heads of Departments Delegated by the Director of the Department of Human Resources Development ("DHRD").*

Pursuant to a delegation of the authority by the Director of DHRD, I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to § 76-16, Hawaii Revised Statutes (HRS).

(Signature) _____ (Date) _____

(Print Name) _____

(Print Title) _____

* This part of the form may be used by all department heads and the heads of attached agencies to whom the Director of DHRD expressly has delegated authority to certify § 76-16, HRS, civil service exemptions. The specific paragraph(s) of § 76-16, HRS, upon which an exemption is based should be noted in the contract file. If an exemption is based on § 76-16(b)(15), the contract must meet the following conditions:

(1) It involves the delivery of completed work or product by or during a specific time;
(2) There is no employee-employer relationship; and
(3) The authorized funding for the service is from other than the "A" or personal services cost element.

NOTE: Not all attached agencies have received a delegation under § 76-16(b)(15). If in doubt, attached agencies should check with the Director of DHRD prior to certifying an exemption under § 76-16(b)(15). Authority to certify exemptions under §§76-16(b)(2), and 76-16(b)(12), HRS, has not been delegated; only the Director of DHRD may certify §§ 76-16(b)(2), and 76-16(b)(12) exemptions.

2. By the Director of DHRD, State of Hawaii.

I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to §76-16, HRS.

(Signature) _____ (Date) _____

(Print Name) _____

(Print Title, if designee of the Director of DHRD) _____

STATE OF HAWAII

SPECIAL CONDITIONS

GENERAL CONDITIONS

Table of Contents

1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.

2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

   a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.

   b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.

   c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.

   d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

   e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.

   f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

a. The CONTRACTOR shall secure, at the CONTRACTOR'S own expense, all personnel required to perform this Contract.

b. The CONTRACTOR shall ensure that the CONTRACTOR'S employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the CONTRACTOR, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

5. Conflicts of Interest. The CONTRACTOR represents that neither the CONTRACTOR, nor any employee or agent of the CONTRACTOR, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the CONTRACTOR'S performance under this Contract.

6. Subcontracts and Assignments. The CONTRACTOR shall not assign or subcontract any of the CONTRACTOR'S duties, obligations, or interests under this Contract and no such assignment or subcontract shall be effective unless (i) the CONTRACTOR obtains the prior written consent of the STATE, and (ii) the CONTRACTOR'S assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR'S assignee or subcontractor have been paid. Additionally, no assignment by the CONTRACTOR of the CONTRACTOR'S right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in section 40-58, HRS.

a. Recognition of a successor in interest. When in the best interest of the State, a successor in interest may be recognized in an assignment contract in which the STATE, the CONTRACTOR and the assignee or transferee (hereinafter referred to as the "Assignee") agree that:

(1) The Assignee assumes all of the CONTRACTOR'S obligations;

(2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and

(3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

b. Change of name. When the CONTRACTOR asks to change the name in which it holds this Contract with the STATE, the procurement officer of the purchasing agency (hereinafter referred to as the "Agency procurement officer") shall, upon receipt of a document acceptable or satisfactory to the

Agency procurement officer indicating such change of name (for example, an amendment to the CONTRACTOR'S articles of incorporation), enter into an amendment to this Contract with the CONTRACTOR to effect such a change of name. The amendment to this Contract changing the CONTRACTOR'S name shall specifically indicate that no other terms and conditions of this Contract are thereby changed.

c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.

d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.

7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.

9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.

10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.

11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.

12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.

a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified period

not exceeding sixty (60) days after the order is delivered to the CONTRACTOR, unless the parties agree to any further period. Any such order shall be identified specifically as a stop performance order issued pursuant to this section. Stop performance orders shall include, as appropriate: (1) A clear description of the work to be suspended; (2) Instructions as to the issuance of further orders by the CONTRACTOR for material or services; (3) Guidance as to action to be taken on subcontracts; and (4) Other instructions and suggestions to the CONTRACTOR for minimizing costs. Upon receipt of such an order, the CONTRACTOR shall forthwith comply with its terms and suspend all performance under this Contract at the time stated, provided, however, the CONTRACTOR shall take all reasonable steps to minimize the occurrence of costs allocable to the performance covered by the order during the period of performance stoppage. Before the stop performance order expires, or within any further period to which the parties shall have agreed, the Agency procurement officer shall either:

(1) Cancel the stop performance order; or

(2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.

b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:

(1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and

(2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.

d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

a. Default. If the CONTRACTOR refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency procurement officer may notify the CONTRACTOR in writing of the delay or non-performance and if not cured in ten (10) days or any longer time specified in writing by the Agency procurement officer, such officer may terminate the CONTRACTOR'S right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency procurement officer may procure similar goods or services in a manner and upon the terms deemed appropriate by the Agency procurement officer. The CONTRACTOR shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

b. CONTRACTOR'S duties. Notwithstanding termination of the Contract and subject to any directions from the Agency procurement officer, the CONTRACTOR shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest.

c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.

d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.

e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.

f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

a. Termination. The Agency procurement officer may, when the interests of the STATE so require, terminate this Contract in whole or in part, for the convenience of the STATE. The Agency procurement officer shall give written notice of the termination to the CONTRACTOR specifying the part of the Contract terminated and when termination becomes effective.

b. CONTRACTOR'S obligations. The CONTRACTOR shall incur no further obligations in connection with the terminated performance and on the date(s) set in the notice of termination the CONTRACTOR will stop performance to the extent specified. The CONTRACTOR shall also terminate outstanding orders and subcontracts as they relate to the terminated performance. The CONTRACTOR shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated performance subject to the STATE'S approval. The Agency procurement officer may direct the CONTRACTOR to assign the CONTRACTOR'S right, title, and interest under terminated orders or subcontracts to the STATE. The CONTRACTOR must still complete the performance not terminated by the notice of termination and may incur obligations as necessary to do so.

c. Right to goods and work product. The Agency procurement officer may require the CONTRACTOR to transfer title and deliver to the STATE in the manner and to the extent directed by the Agency procurement officer:

(1) Any completed goods or work product; and

(2) The partially completed goods and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the CONTRACTOR has specifically produced or specially acquired for the performance of the terminated part of this Contract.

The CONTRACTOR shall, upon direction of the Agency procurement officer, protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest. If the Agency procurement officer does not exercise this right, the CONTRACTOR shall use best efforts to sell such goods and manufacturing materials. Use of this paragraph in no way implies that the STATE has breached the Contract by exercise of the termination for convenience provision.

d. Compensation.

(1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.

(2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.

(3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:

(A) Contract prices for goods or services accepted under the Contract;

(B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;

(C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);

(D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the total Contract price plus the reasonable settlement costs of the CONTRACTOR reduced by the amount of payments otherwise made, the proceeds of any sales of

supplies and manufacturing materials under subparagraph 14d(2), and the contract price of performance not terminated.

(4) Costs claimed, agreed to, or established under subparagraphs 14d(2) and 14d(3) shall be in accordance with Chapter 3-123 (Cost Principles) of the Procurement Rules.

15. Claims Based on the Agency Procurement Officer's Actions or Omissions.

a. Changes in scope. If any action or omission on the part of the Agency procurement officer (which term includes the designee of such officer for purposes of this paragraph 15) requiring performance changes within the scope of the Contract constitutes the basis for a claim by the CONTRACTOR for additional compensation, damages, or an extension of time for completion, the CONTRACTOR shall continue with performance of the Contract in compliance with the directions or orders of such officials, but by so doing, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, damages, or an extension of time for completion; provided:

(1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:

(A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;

(B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or

(C) Within such further time as may be allowed by the Agency procurement officer in writing.

(2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;

(3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and

(4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

b. CONTRACTOR not excused. Nothing herein contained, however, shall excuse the CONTRACTOR from compliance with any rules or laws precluding any state officers and CONTRACTOR from acting in collusion or bad faith in issuing or performing change orders which are clearly not within the scope of the Contract.

c. Price adjustment. Any adjustment in the price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

16. Costs and Expenses. Any reimbursement due the CONTRACTOR for per diem and transportation expenses under this Contract shall be subject to chapter 3-123 (Cost Principles), HAR, and the following guidelines:

a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.

b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.

c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.

b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.

c. Prompt payment.

(1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and

(2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.

d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

18. Federal Funds. If this Contract is payable in whole or in part from federal funds, CONTRACTOR agrees that, as to the portion of the compensation under this Contract to be payable from federal funds, the CONTRACTOR shall be paid only from such funds received from the federal government, and shall not be paid from any other funds. Failure of the STATE to receive anticipated federal funds shall not be considered a breach by the STATE or an excuse for nonperformance by the CONTRACTOR.

19. Modifications of Contract.

a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.

b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:

(A) Changes in the work within the scope of the Contract; and

(B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.

d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.

e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.

f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.

g. CPO approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least $25,000.00 or ten per cent (10%) of the initial contract price, whichever increase is higher, must receive the prior approval of the CPO.

h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.

i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.

20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:

(1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;

(2) Method of delivery; or

(3) Place of delivery.

a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By proceeding with the work, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, or any extension of time for completion.

b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.

c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.

d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:

(1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;

(2) By unit prices specified in the Contract or subsequently agreed upon;

(3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;

(4) In such other manner as the parties may mutually agree; or

(5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.

b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

22. Variation in Quantity for Definite Quantity Contracts. Upon the agreement of the STATE and the CONTRACTOR, the quantity of goods or services, or both, if a definite quantity is specified in this Contract, may be increased by a maximum of ten per cent (10%); provided the unit prices will remain the same except for any price adjustments otherwise applicable; and the Agency procurement officer makes a written determination that such an increase will either be more economical than awarding another contract or that it would not be practical to award another contract.

23. Changes in Cost-Reimbursement Contract. If this Contract is a cost-reimbursement contract, the following provisions shall apply:

a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:

(1) Description of performance (Attachment 1);

(2) Time of performance (i.e., hours of the day, days of the week, etc.);

(3) Place of performance of services;

(4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;

(5) Method of shipment or packing of supplies; or

(6) Place of delivery.

b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.

c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.

d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.

e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.

24. Confidentiality of Material.

a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.

25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.

26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.

27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:

a. The cost or pricing data, and

b. A state contract, including subcontracts, other than a firm fixed-price contract.

29. Cost or Pricing Data. Cost or pricing data must be submitted to the Agency procurement officer and timely certified as accurate for contracts over $100,000 unless the contract is for a multiple-term or as otherwise specified by the Agency procurement officer. Unless otherwise required by the Agency procurement officer, cost or pricing data submission is not required for contracts awarded pursuant to competitive sealed bid procedures.

If certified cost or pricing data are subsequently found to have been inaccurate, incomplete, or noncurrent as of the date stated in the certificate, the STATE is entitled to an adjustment of the contract price, including profit or fee, to exclude any significant sum by which the price, including profit or fee, was increased because of the defective data. It is presumed that overstated cost or pricing data increased the contract price in the amount of the defect plus related overhead and profit or fee. Therefore, unless there is a clear indication that the defective data was not used or relied upon, the price will be reduced in such amount.

30. Audit of Cost or Pricing Data. When cost or pricing principles are applicable, the STATE may require an audit of cost or pricing data.

31. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

32. Antitrust Claims. The STATE and the CONTRACTOR recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the CONTRACTOR hereby assigns to STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

33. Patented Articles. The CONTRACTOR shall defend, indemnify, and hold harmless the STATE, and its officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys fees, and all claims, suits, and demands arising out of or resulting from any claims, demands, or actions by the patent holder for infringement or other improper or unauthorized use of any patented article, patented process, or patented appliance in connection with this Contract. The CONTRACTOR shall be solely responsible for correcting or curing to the satisfaction of the STATE any such infringement or improper or unauthorized use, including, without limitation: (a) furnishing at no cost to the STATE a substitute article, process, or appliance acceptable to the STATE, (b) paying royalties or other required payments to the patent holder, (c) obtaining proper authorizations or releases from the patent holder, and (d) furnishing such security to or making such arrangements with the patent holder as may be necessary to correct or cure any such infringement or improper or unauthorized use.

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or

in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.

35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.

36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.

38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.

40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.

41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-205.5, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.

42. Confidentiality of Personal Information.

a. Definitions.

"Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

(1) Social security number;

(2) Driver's license number or Hawaii identification card number; or

(3) Account number, credit or debit card number, access code, or password that would permit

access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

"Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

b. Confidentiality of Material.

(1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.

(2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

(3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

(4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

(5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.

(6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

(1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.

(2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

(A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;

(B) Access to the personal information will be allowed only as necessary to perform the Contract; and

(C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

d. Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

Appendix D
Questions for Offerors

(Option to provide your answers via an electronic file
created by Aon is available upon request)

I. GENERAL PLAN INFORMATION

1. PPO Plan Name
2. Street Address
3. City
4. State
5. Zip
6. Web Address
7. PPO Operational Date
8. Corporate Tax Status
9. PPO Ownership/Controlling Interest
10. NCQA Accreditation Status
11. JCAHO Accreditation
12. URAC Accreditation
    a. Health Plan
    b. Health Network
    c. Health Utilization Management
13. PPO Commercial Group Membership
14. If the PPO's rating has changed within the past 12 months for any of the rating agencies, indicate new rating and the date received in the appropriate box. If the rating has not changed, put "Not Changed" in the Rating cell.
    a. A.M. Best: Rating Status
       Financial Rating (if rated)
       Date (if rated; if not rated, leave response cell blank)
    b. Standard & Poor's: Rating Status
       Financial Rating (if rated)
       Date (if rated; if not rated, leave response cell blank)
    c. Fitch: Rating Status
       Financial Rating (if rated)
       Date (if rated; if not rated, leave response cell blank)
    d. Moody's: Rating Status
       Financial Rating (if rated)
       Date (if rated; if not rated, leave response cell blank)

Contacts

Please indicate the appropriate contact, should there be any questions concerning submitted responses.

15. Primary Contact
    a. Name
    b. Title
    c. Address
    d. City
    e. State
    f. Zip
    g. Phone Number
    h. Fax Number
    i. E-mail Address
16. Secondary Contact
    a. Name
    b. Title
    c. Address
    d. City
    e. State
    f. Zip
    g. Phone Number
    h. Fax Number
    i. E-mail Address

Please answer "Yes" or "No", unless noted otherwise.

II. PLAN DESIGN/FINANCIAL INFORMATION

Adhere to the proposed plan designs shown in Appendix N in preparing the quotes.

1. The proposal is issued in accordance with the specifications, assumptions and information included in this Request for Proposal, the accompanying worksheets and standard services addressed in the Request for Information previously submitted. If "No", indicate deviations in "Explanation" column and/or worksheet.

Plan Design

2. Review and detail deviations from the proposed plan(s) design shown in Appendix N.
3. For fully-insured coverages, include a detailed description of the proposed plan(s) design, including any riders, if quoted. Name the file: [Offeror's Name]_ProposedPlanDescription.
4. Include a concise description of how this health plan covers transitional conditions, such as pregnancy, chemotherapy, etc., if a new member is receiving treatment

from a non-participating provider. Name the file: [Offeror's Name]_TransitionalCare.

5. For those employees outside of your service area, provide a proposed out-of-area plan design. Name the file: [Offeror's Name]_OutofArea_ Plan.

Financial - Underwriting Requirements/Premium Quotation

6. For the fully-insured coverages requested, do you have minimum participation requirements in order to underwrite this particular group?
   a. If "Yes", what is the minimum number or percentage of employees required to enroll in order to underwrite the group?
   b. Does this figure include those employees waiving coverage?
7. For the fully-insured coverages requested, are there underwriting requirements for this initial group of plan participants? If so, please provide the requirements below:
   a. Underwriting reason #1 (e.g., minimum employer contributions)
   b. Underwriting reason #2 (e.g., medical evidence)
   c. Underwriting reason #3 (please specify)
8. For the fully-insured coverages requested, is the EUTF required to place other lines of coverage (i.e. minimum basic life, etc.) in order to secure the medical coverage requested. If "Yes", indicate specifics in "Explanation" column and/or worksheet.
9. For fully-insured quotes, provide your financial quotation in the worksheet in Appendix E.
10. If you were requested to provide guaranteed rates or rate caps beyond the first contract period, have you included the rates or caps in the financial quotation?
11. If you were provided with a Risk Evaluation Form, did you reflect the medical information included on the form in your quote?
12. For fully-insured quotes, describe the rating method used to develop the proposed rates
13. For fully-insured quotes, describe the rating method which will be used in subsequent renewals:
    a. PPO Quotes
14. Describe the terms and conditions under which you have the right to modify the rates or administrative agreement and/or its fees. If you need more space, please use the "Explanation" column and/or worksheet.
15. The quoted rates/fees will not include commissions.
16. The quoted rates will be reduced if your PPO is the only PPO offered in this market.

Financial - Renewal Services

For the funding arrangement requested in this RFP, please indicate your willingness to comply with the following renewal requirements and services:

17. For fully-insured coverages requested, renewal underwriting of rates is to be completed annually with any adjustments effective on the contract anniversary date, unless an alternate date is mutually agreed to in advance by the EUTF.
18. For fully-insured coverages requested, renewal rates (to be accompanied with an experience summary report) are to be provided at least 180 days in advance of the contract anniversary date.
19. Renewal rates/administrative fees shall be guaranteed for a minimum of 12 months from the contract anniversary date, unless an alternate date is mutually agreed to in advance by the EUTF.

III. MEDICAL DELIVERY SYSTEM

1. Please attach a copy of the provider directory(ies) for all locations for which you are quoting. Name the file: [Offeror's Name]_ProviderDirectories.
2. List participating Acute Care Hospitals for the geographic locations as shown in the worksheet(s), "Hosp".
3. Provide the number of participating physicians by specialty for the geographic locations shown in the worksheet(s), "Doc".

Employees' Access to Providers

4. Using the census data provided, prepare a list to indicate which employees reside within and outside of your service area. Name the file: [Offeror's Name]_ServiceAreaSummary.

IV. ADMINISTRATIVE AND OPERATIONAL ISSUES

Implementation Services

1. Prepare a detailed schedule and time frame to implement this program by the effective date. Please indicate the implementation responsibilities of offeror, the EUTF and Aon. Name the file: [Offeror's Name]_Implementation.
2. Design, submit for the EUTF's approval, and print forms with the EUTF's logo for claims submission, where required.
3. If requested, provide network service area zip codes and electronic directories for the EUTF's voice enrollment system.
4. Load, audit and insure clean eligibility data at least 5 days prior to program effective date.
5. Send plan representatives to the worksite to conduct new member orientations for groups having 25+ employees at no additional charge.

Other Services

6. List the location(s) of your service centers that would be servicing the EUTF's employees and the corresponding geographic areas/regions covered by the respective location. Use the "Explanation" column and/or worksheet if you need more space.
   a. Service Center 1
      Location 1
      Geographic Region(s) Covered 1
   b. Service Center 2
      Location 2
      Geographic Region(s) Covered 2
   c. Service Center 3
      Location 3
      Geographic Region(s) Covered 3
7. Indicate which conversion plans are offered post-COBRA coverage; if offered, indicate the name of insuring entity.
   a. PPO
      Offered/Not Offered?
      Name of Insuring Entity
   b. HMO
      Offered/Not Offered?
      Name of Insuring Entity
   c. Other Plan Design
      Offered/Not Offered?
      Name of Insuring Entity
8. Attach a description of premium or administrative fee billing procedures. Include information on the timing of billing, billing-payment reconciliations and ability to provide for client self-billing. Name the file: [Offeror's Name]_PremiumBilling.
9. The plan will contain the birthday rule and will have group to group coordination of benefits provision.
10. To the extent permitted under state law, no fault auto insurance, governmental plans coordination and negligent third party subrogation will be administered.
11. Please attach a copy of a plan experience report that would be provided to the EUTF at the end of the first year. Name the file: [Offeror's Name]_MgmtRptgPkg.
12. The offeror will pay for printing costs for:
    a. ID Cards
    b. Booklets
    c. Certificates
    d. SPDs

V. LEGAL/CONTRACTUAL CONSIDERATIONS

1. Offeror has complied with all state insurance department filing requirements for all

plans/products being offered in this quote in each state in which the EUTF has employees.

   a. If the answer to the preceding question is "no", for all plans/products quoted in this RFP for which the required state insurance department filing requirements have not been met, please specify the applicable plan/product and corresponding state

2. Offeror is bonded.
3. Liability insurance covers:
   a. Medical management decisions.
   b. Professional malpractice
   c. Provider contracting
4. Please describe any judgment or settlement during the past three years or pending litigation that could result in judgments or settlements in excess of $100,000.
5. The offeror maintains executed contracts with all providers participating in the network.
6. The offeror's provider contracts do not provide for any type of remuneration to offeror, such as commission, finder's fee, rebate, or other financial benefit.
7. The offeror is not a creditor of any provider in the network.
8. For this proposal, confirm that the risk is held entirely by the offeror. (Applicable to fully-insured coverages.)
   a. If it is not, indicate the percentage of the risk passed on to other firms.
   b. Provide treaty details of any ceded risk. If you need more space, please use the "Explanation" column and/or Worksheet.
9. Offeror agrees to prepare and file all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts, and required state filings.
10. Offeror agrees to provide necessary legal defense in the event of litigation, including all costs inuring thereto.
11. Offeror agrees to indemnify and hold the EUTF harmless for offeror's negligence or for offeror's failure to perform under the Agreement. the EUTF shall not provide any indemnity in favor of the offeror.

Contractual

12. October 01, 2009 is to be the contract effective date.
13. The contract will be issued in Hawaii..
14. July 1 will be the first contract anniversary date.
15. The offeror agrees not to appoint any agent, general agent, or broker, nor authorize payment of any kind to a party not approved in writing by the EUTF.
16. We understand that terminology and contract provisions may vary among the involved offerors. We will permit such alternative language provided benefit payment levels are not adversely impacted.

17. The offeror shall cause the EUTF and its welfare program to be the named insured thereunder. The offeror shall provide proof of such insurance to the EUTF at or prior to the execution of the contract.
18. There will be no restrictions or benefit limitations for pre-existing conditions applied to any members enrolled in the plan/program at any time.
19. No Loss/No Gain Provision: The insurer must provide coverage on a discontinuance and replacement basis (sometimes referred to as a "no loss/no gain" basis) for eligible employees (and dependents) participating in the current plans on the effective date and to unconditionally provide continuous coverage to all participants enrolled on the program effective date.
20. Waiver of Actively at Work Provisions: Any participants not actively at work due to disablement on the program effective date will be covered.
21. No statement of health or medical evidence will be imposed upon the initial group of covered participants.
22. Any disabled employees (or enrolled dependents) or other leave-of-absence employees who are inadvertently not disclosed in these specifications or who later are identified as eligible for benefits with the incumbent offeror will become the liability of the offeror selected through this marketing.

Future Contract Termination

23. The offeror selected during this proposal process will be responsible for incurred claims up to the termination date of the contract, regardless of paid date, in the event the contract awarded during this marketing is subsequently terminated. The replacement offeror will have the responsibility to pay claims incurred after the termination date of the contact.(Applicable to fully-insured coverages)
24. The offeror selected during this proposal process will be responsible to maintain coverage for persons who are hospital-confined on the date the agreement terminates until the individual is discharged, regardless of paid date, in the event the contract awarded during this marketing is subsequently terminated. (Applicable to fully-insured coverages)

Compliance, General

25. Offeror agrees that it will honor repayment demands or requests for reimbursement that are made within the 3-year period for Medicare to recover improper payments.
26. The offeror agrees to comply with the Department of Labor's final claims procedure regulations, including the appropriate timeframes for adjudicating claims and notice of appeal decisions.

Compliance, HIPAA

27. You maintain a dedicated individual or staff responsible for resolving HIPAA issues.
28. Offeror certifies that it will comply with the interim final rules on nondiscrimination in the group health market, including:
    a. Coverage for self-inflicted injuries for persons who suffer from medical conditions (such as depression)
    b. Coverage for persons who are hospital-confined or not actively at work when coverage would otherwise take effect.
29. Offeror certifies that it reports to the national Healthcare Integrity and Protection Databank (HIPDB) as required and, as may be necessary, submits inquiries to the HIPDB to determine whether any final adverse legal actions have been taken against its member providers.
30. Offeror certifies that, if it conducts Standard Transactions, it is in full compliance with HIPAA's administrative simplification standards relating to electronic data interchange (EDI).
31. Offeror will not require that enrollment and eligibility information electronically transmitted by EUTF to offeror comply with EDI.

Compliance, Privacy and Confidentiality

32. The offeror agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by offeror available to the Secretary of the Department of Health and Human Services for purposes of the Secretary of the Department of Health and Human Services determining offeror's compliance with the privacy rules.
33. The offeror adopts and implements written confidentiality policies and procedures in accordance with applicable law to ensure the confidentiality of member information used for any purpose.
34. The offeror will not use or further disclose protected health information (PHI) other than as permitted or required by the Business Associate Agreement or as required by law.
35. The offeror agrees to use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. Offeror agrees to report to the plan sponsor any unauthorized use or disclosure of the PHI.
36. The offeror agrees to mitigate, to the extent practicable, any harmful effect that is known to offeror of a use or disclosure of PHI by offeror in violation of the requirements of the federal privacy rule.
47. The offeror agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the offeror agrees to the same restrictions and conditions that apply to offeror with respect to such information.

48. The offeror agrees to provide access to PHI in a "designated record set" in order to meet the requirements under 45 CFR §164.524.
49. The offeror agrees to make any amendment(s) to PHI in a "designated record set" pursuant to 45 CFR §164.526.
50. The offeror agrees to document such disclosures of PHI and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.
51. The offeror agrees to (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits, (ii) report to the plan sponsor any security incident (within the meaning of 45 CFR § 164.304) of which offeror becomes aware, and (iii) ensure that any offeror employee or agent, including any subcontractor to whom it provides PHI received from, or created or received by the offeror agrees to implement reasonable and appropriate safeguards to protect such PHI.

VI. OTHER INFORMATION

Please provide the following information in electronic format and name the file as specified:

1. A copy of your most recent audited financial statement. Name the file: [Offeror's Name]_Audited Financial Statement.
2. A description of the health plan's conversion plan(s) and associated costs. Name the file: [Offeror's Name]_Conversion Services.
3. A copy of the health plan's appeal and grievance policies, if not specified in the Suggested Employer Contract. Name the file: [Offeror's Name] _Appeal_Grievance Policies.
4. Current marketing materials that would be of assistance to Aon Consulting and the EUTF in evaluating your program. Name the file: [Offeror's Name]_MarketingMaterials.
5. Sample ID Card and description of elements that may be customized. Name the file: [Offeror's Name]_IDCard.
6. Current member enrollment materials that the health plan feels would be of assistance to Aon Consulting and the EUTF in evaluating your program. Name the file: [Offeror's Name]_EnrollmentMaterials.
7. Please provide three of your employer client references of similar size in the network locations that will be serving most of the EUTF's employees.
   a. Reference #1
      Company Name
      Contact Person
      Title

Phone Number
Fax Number
E-mail Address
Network Name
PPO Members Enrolled

b. Reference #2
Company Name
Contact Person
Title
Phone Number
Fax Number
E-mail Address
Network Name
PPO Members Enrolled

c. Reference #3
Company Name
Contact Person
Title
Phone Number
Fax Number
E-mail Address
Network Name
PPO Members Enrolled

Appendix E
Rate Proposal Forms

Additional columns are provided for Alternate Plan Design Proposals (optional)

ACTIVE EMPLOYEES				
Premiums	**Plan Design #1 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #2 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #3 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #4 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**
Single				
Two Party				
Family				

ACTIVE EMPLOYEES				
Premiums	**Plan Design #5 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #6 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #7 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Plan Design #8 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**
Single				
Two Party				
Family				

ACTIVE EMPLOYEES				
Premiums	**Alt Design #1 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #2 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #3 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #4 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**
Single				
Two Party				
Family				

RETIREES				
Premiums	**Plan Design #1 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #1 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #2 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**	**Alt Design #3 10/1/09 – 6/30/10; 7/1/10 – 6/30/11**
Single				
Two Party				
Family				

EXTENSION GUARANTEES (ACTIVES)	**Rates for Plan Year Ending**	
	June 30, 2012	**June 30, 2013**
Maximum Rate Cap		
Maximum Trend		
Maximum Retention		

EXTENSION GUARANTEES (RETIREES)	**Rates for Plan Year Ending**	
	June 30, 2012	**June 30, 2013**
Maximum Rate Cap		
Maximum Trend		
Maximum Retention		

Appendix F
Offer Form OF-1

Offeror Name: _____

Location of Home Office: _____

Location of Honolulu Office (if any): _____

Primary Contact: _____

Address: _____

City/State/Zip: _____

Telephone: _____ FAX: _____

The undersigned proposes to provide health and other benefit plans of the Hawaii Employer-Union Health Benefit Trust Fund's ("EUTF") as set forth in this proposal, all in strict compliance with the specifications, terms, and conditions set forth in RFP No. 09-002, and any modifications, amendments, and addenda issued to that RFP.

The undersigned states that he or she has carefully read and understands the terms and conditions of the sample contract (including the General Conditions) and agrees that the EUTF reserves the right to cancel the RFP, or reject any or all proposals, or waive any defects when, in their opinion, such is in the best interest of the EUTF and State of Hawaii.

The undersigned certifies that this proposal is not in violation of Section 84-15, Hawaii Revised Statutes, concerning prohibited State contracts, and is certifying that the price(s) submitted was (were) independently arrived at without collusion.

The undersigned represents: **(Check √ one only)**

- ☐ A **Hawaii business** incorporated or organized under the laws of the State of Hawaii; **OR**
- ☐ A **compliant Non-Hawaii business** not incorporated or organized under the laws of the State of Hawaii, but registered at the State of Hawaii Department of Commerce and Consumer Affairs Business Registration Division to do business in the State of Hawaii.

State of incorporation: _____

Offeror is:

☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Joint Venture
☐ Other _____

Federal I.D. No.: _____
Hawaii General Excise Tax License I.D. No.: _____
Payment address (other than street address below): _____

City, State, Zip Code:_____

Business address (street address): _____

City, State, Zip Code:_____

Respectfully Submitted:

*Authorized Original Signature: _____

Name and Title (Please Type or Print): _____

**Exact Legal Name of Company (Offeror): _____

Date: _____

*Please attach to this page notarized evidence of the authority of this officer to submit a proposal on behalf of Offeror.

**If Offeror is a "dba" or a "division" of a corporation, furnish the exact legal name of the corporation under which the awarded contract will be executed.

Appendix G
Wage Certification

Subject: To furnish, supply, and deliver Services for the Hawaii Employer-Union Health Benefits Trust Fund

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract in excess of $25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid at wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.

2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required by Federal and State laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, Hawaii Revised Statutes.

Applicant: _____

Signature: _____

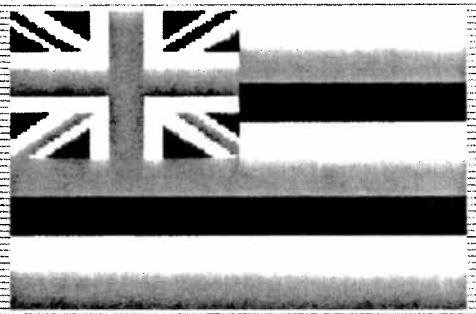
Title: _____

Date: _____

Appendix H
Aon Risk Services, Inc. of Hawaii Annual Report

State of Hawaii - EUTF

ANNUAL REPORT
PLAN YEAR 2007-2008
December 8, 2008



AON Consulting

Revised 2/25/09

Table of Contents

Hawaii Employer-Union Health Benefits Trust Fund
Annual Report covering the period July 1, 2007 through June 30, 2008

Table of Contents (continued)

Table of Contents (continued)

Table of Contents (continued)

Table of Contents (continued)

Table of Contents (continued)

Table of Contents (continued)

Plan Financial Summary - Actives

	Premiums Received	Benefits Paid + Admin Fees	Surplus/(Deficit)
Self Funded			
HMSA PPP Plan	$ 136,726,185	$ (168,970,462)	**$ (32,244,277)**
HMA PPP Plan	$ 1,931,570	$ (2,044,753)	**$ (113,183)**
HMSA HMO Plan	$ 6,566,770	$ (8,467,564)	**$ (1,900,794)**
HMSA HDHP Plan	$ 322,478	$ (78,469)	**$ 244,009**
HMSA Supplemental Plan	$ 2,104,689	$ (2,398,781)	**$ (294,091)**
NMHC Drug Plan	$ 34,331,415	$ (44,539,937)	**$ (10,208,522)**

	Premiums Paid	Total Plan Costs	Surplus/(Deficit)
Fully Insured			
Kaiser Medical & Drug	$ 54,701,976	$ (50,506,095)	**$ 4,195,881**
RSN Supplemental	$ 619,610	$ (557,650)	**$ 61,960**
RSN Chiropractic Plan	$ 1,099,535	$ (1,080,250)	**$ 19,285**
HDS Dental Plan	$ 29,682,001	$ (30,643,376)	**$ (961,375)**
VSP Vision Plan	$ 5,110,958	$ (4,769,299)	**$ 341,659**
Standard Life Insurance	$ 2,675,219	$ (2,499,367)	**$ 175,852**

Revised 2/25/09

AON

Plan Financial Summary - Retirees

	Premiums Received	Benefits Paid + Admin Fees	Surplus/(Deficit)
Self Funded			
HMSA Medical - Retirees without Medicare	$ 42,745,460	$ (42,258,722)	**$ 486,739**
HMSA Medical - Retirees with Medicare	$ 42,433,096	$ (47,948,999)	**$ (5,515,903)**
HMA Medical - Retirees without Medicare	$ 68,232	$ (62,126)	**$ 6,106**
HMA Medical - Retirees with Medicare	$ 26,207	$ (35,237)	**$ (9,030)**
NMHC Drug Plan - Retirees without Medicare	$ 17,355,044	$ (20,195,036)	**$ (2,839,992)**
NMHC Drug Plan - Retirees with Medicare	$ 54,258,950	$ (64,430,479)	**$ (10,171,529)**

	Premiums Paid	Total Plan Costs	Surplus/(Deficit)
Fully Insured			
Kaiser Retiree Medical & Drug	$ 32,373,387	$ (53,200,000)	**$ (20,826,613)**
HDS Retiree Dental Plan	$ 16,943,979	$ (17,144,704)	**$ (200,724)**
VSP Retiree Vision Plan	$ 2,749,398	$ (2,798,411)	**$ (49,013)**
Standard Life Insurance	$ 1,574,017	$ (1,618,747)	**$ (44,730)**

Revised 2/25/09

Plan Contribution Summary

CONTRIBUTIONS	FY2007 Active	FY2007 Retired	FY2007 Total	FY2008 Active	FY2008 Retired	FY2008 Total	% Active	% Retired	% Total
Medical/Drug/Chiro	150,669,297	182,267,477	332,936,774	147,899,293	199,736,728	347,636,021	-1.8%	9.6%	4.4%
Medicare	0	38,064,777	38,064,777	0	40,766,805	40,766,805	--	7.1%	7.1%
SUBTOTAL MEDICAL	150,669,297	220,332,254	371,001,551	147,899,293	240,503,533	388,402,826	-1.8%	9.2%	4.7%
Dental	21,303,739	17,773,293	39,077,032	20,494,429	17,074,231	37,568,660	-3.8%	-3.9%	-3.9%
Vision	2,766,471	3,001,901	5,768,372	3,087,104	2,771,347	5,858,450	11.6%	-7.7%	1.6%
Life Insurance	2,625,797	1,589,744	4,215,541	2,695,755	1,578,818	4,274,573	2.7%	-0.7%	1.4%
TOTAL EMPLOYER CONTRIBUTIONS	177,365,304	242,697,192	420,062,496	174,176,580	261,927,928	436,104,508	-1.8%	7.9%	3.8%
TOTAL EMPLOYEE CONTRIBUTIONS	112,622,427	283,367	112,905,794	115,189,280	460,793	115,650,073	2.3%	62.6%	2.4%
GRAND TOTAL CONTRIBUTIONS	289,987,731	242,980,559	532,968,290	289,365,860	262,388,721	551,754,581	-0.2%	8.0%	3.5%

Revised 2/25/09

Plan Enrollment Summary

	FY2007			FY2008			%		
	Active	Retired	Total	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro Plan	42,485	35,588	78,073	44,082	36,086	80,168	3.8%	1.4%	2.7%
Medicare Reimbursements	0	27,445	27,445	0	28,336	28,336	--	3.2%	3.2%
Dental Plan	45,217	35,224	80,441	46,387	35,726	82,113	2.6%	1.4%	2.1%
Vision Plan	42,782	35,465	78,247	44,012	36,010	80,022	2.9%	1.5%	2.3%
Life Insurance	52,857	31,523	84,380	54,635	31,994	86,629	3.4%	1.5%	2.7%

Subscriber Enrollment Count as of June 30, 2008 by BU

	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HGEA	UHPA
	00	01	02	03	04	06	07
Medical/Drug/Chiro Plan	1,175	7,513	654	12,129	515	704	3,316
Dental Plan	1,262	7,777	675	13,066	571	743	3,396
Vision Plan	1,182	7,453	651	12,393	546	705	3,154
Life Insurance	1,521	8,950	777	15,864	663	898	3,992

	HGEA	HGEA	UPW	HFFA	SHOPO	HGEA	GRAND
	08	09	10	11	12	13	TOTAL
Medical/Drug/Chiro Plan	2,666	1,244	2,531	1,644	2,585	7,744	44,420
Dental Plan	2,632	1,289	2,619	1,718	2,649	8,183	46,580
Vision Plan	2,432	1,234	2,516	1,572	2,550	7,793	44,181
Life Insurance	3,229	1,483	3,005	1,952	2,951	9,622	54,907

Revised 2/25/09

SECTION 1: Disbursements & Contributions

Table 1 – Disbursements for Carrier Premiums and Medicare Reimbursements

	2006-2007	2007-2008	% Change
***Self Insured Plans (Benefits Paid+Admin Fee):**			
Medical Plans			
HMSA		$ 270,122,997	
HMA		$ 2,142,116	
Drug Plan			
NMHC		$ 129,165,452	
TOTAL BENEFITS PAID & ADMIN FEE		$ 401,430,564	
Premiums for Fully Insured Plans:			
Medical & Prescription Drug Plans			
HMSA	$ 341,289,765		
Kaiser	$ 85,576,938	$ 87,075,363	1.8%
RSN	$ 632,520	$ 619,610	-2.0%
Chiropractic Plan			
RSN/ MBAH	$ 1,035,489	$ 1,099,535	6.2%
Dental Plan			
HDS	$ 48,934,825	$ 46,625,980	-4.7%
Vision Care Plan			
VSP	$ 7,299,082	$ 7,860,356	7.7%
Life Insurance Plan			
Standard/ Aetna	$ 4,197,588	$ 4,249,236	1.2%
TOTAL (Self Insured + Fully Insured Plans)	$ 488,966,207	$ 548,960,644	12.3%
MEDICARE PREMIUM REIMBURSEMENTS	$ 38,064,777	$ 40,766,805	7.1%
TOTAL PAYMENTS TO CARRIERS + REIMB.	**$ 527,030,984**	**$ 589,727,449**	11.9%

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Payments to Carriers
Benefits Paid (Self Insured) + Premiums Paid (Fully Insured)

FY 2008 PAYMENTS TO CARRIERS

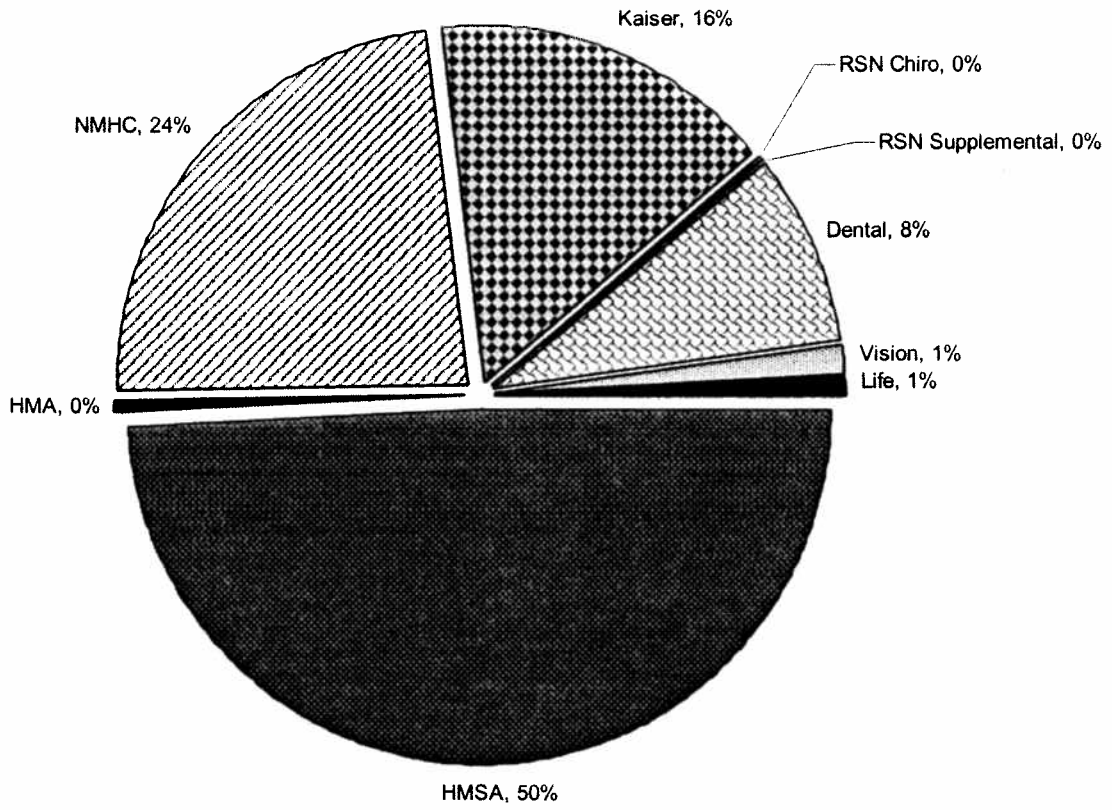

Table 2 – Employer and Employee Contributions

EMPLOYER CONTRIBUTIONS	STATE OF HAWAII			STATE OF HI - HAWAII PUBLIC CHARTER SCHOOLS		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro	102,580,704	139,213,988	241,794,692	376,615	0	376,615
Medicare	0	31,511,597	31,511,597	0	0	0
SUBTOTAL MEDICAL	102,580,704	170,725,585	273,306,289	376,615	0	376,615
Dental	14,198,929	12,249,217	26,448,146	48,909	0	48,909
Vision	2,162,528	1,977,197	4,139,724	7,765	0	7,765
Life Insurance	1,945,004	1,187,842	3,132,846	7,779	0	7,779
TOTAL EMPLOYER CONTRIBUTIONS	120,887,164	186,139,841	307,027,005	441,069	0	441,069
TOTAL EMPLOYEE CONTRIBUTIONS	80,267,174	395,262	80,662,436	291,289	0	291,289
GRAND TOTAL CONTRIBUTIONS	201,154,338	186,535,103	387,689,441	732,358	0	732,358

EMPLOYER CONTRIBUTIONS	CITY & COUNTY OF HONOLULU			C & C - BOARD OF WATER SUPPLY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro	25,634,618	38,615,833	64,250,450	1,594,512	3,029,445	4,623,957
Medicare	0	5,883,751	5,883,751	0	670,791	670,791
SUBTOTAL MEDICAL	25,634,618	44,499,583	70,134,201	1,594,512	3,700,236	5,294,747
Dental	3,630,632	3,083,625	6,714,257	226,871	263,933	490,804
Vision	531,794	507,164	1,038,958	33,432	43,036	76,469
Life Insurance	428,617	250,120	678,737	26,874	22,140	49,013
TOTAL EMPLOYER CONTRIBUTIONS	30,225,661	48,340,493	78,566,154	1,881,689	4,029,345	5,911,034
TOTAL EMPLOYEE CONTRIBUTIONS	19,862,665	29,333	19,891,998	1,218,524	1,898	1,220,422
GRAND TOTAL CONTRIBUTIONS	50,088,326	48,369,826	98,458,152	3,100,213	4,031,243	7,131,456

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Table 2 – Employer and Employee Contributions (continued)

EMPLOYER CONTRIBUTIONS	HAWAII COUNTY			HI COUNTY - DEPT. OF WATER SUPPLY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro	7,022,252	8,090,120	15,112,373	504,362	421,803	926,165
Medicare	0	1,037,319	1,037,319	0	78,285	78,285
SUBTOTAL MEDICAL	7,022,252	9,127,440	16,149,692	504,362	500,088	1,004,450
Dental	930,012	612,343	1,542,355	67,349	36,047	103,396
Vision	138,699	101,958	240,657	10,123	5,748	15,871
Life Insurance	111,777	50,467	162,244	8,455	3,041	11,496
TOTAL EMPLOYER CONTRIBUTIONS	8,202,741	9,892,207	18,094,948	590,290	544,924	1,135,214
TOTAL EMPLOYEE CONTRIBUTIONS	5,203,976	9,031	5,213,007	373,231	0	373,231
GRAND TOTAL CONTRIBUTIONS	13,406,717	9,901,238	23,307,955	963,521	544,924	1,508,445

EMPLOYER CONTRIBUTIONS	MAUI COUNTY			KAUAI COUNTY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro	6,874,017	6,486,600	13,360,617	3,312,213	3,878,939	7,191,152
Medicare	0	960,946	960,946	0	624,116	624,116
SUBTOTAL MEDICAL	6,874,017	7,447,546	14,321,563	3,312,213	4,503,055	7,815,268
Dental	939,360	518,476	1,457,837	452,366	310,589	762,955
Vision	135,730	85,388	221,118	67,032	50,856	117,889
Life Insurance	111,569	40,504	152,073	55,680	24,704	80,384
TOTAL EMPLOYER CONTRIBUTIONS	8,060,677	8,091,914	16,152,591	3,887,291	4,889,062	8,776,353
TOTAL EMPLOYEE CONTRIBUTIONS	5,546,723	18,993	5,565,716	2,425,697	6,276	2,431,973
GRAND TOTAL CONTRIBUTIONS	13,607,400	8,110,907	21,718,307	6,312,988	4,895,338	11,208,326

Table 2 – Employer and Employee Contributions (continued)

EMPLOYER CONTRIBUTIONS	GRAND TOTAL		
	Active	Retired	Total
Medical/Drug/Chiro	147,899,293	199,736,728	347,636,021
Medicare	0	40,766,805	40,766,805
SUBTOTAL MEDICAL	147,899,293	240,503,533	388,402,826
Dental	20,494,429	17,074,231	37,568,660
Vision	3,087,104	2,771,347	5,858,450
Life Insurance	2,695,755	1,578,818	4,274,573
TOTAL EMPLOYER CONTRIBUTIONS	174,176,580	261,927,928	436,104,508
TOTAL EMPLOYEE CONTRIBUTIONS	115,189,280	460,793	115,650,073
GRAND TOTAL CONTRIBUTIONS	289,365,860	262,388,721	551,754,581

SECTION 2: Plan Enrollment

Table 3 – Subscriber Enrollment Count as of June 30, 2008

	STATE OF HAWAII			STATE OF HI - HAWAII PUBLIC CHARTER SCHOOLS		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro Plan	31,365	26,401	57,766	137		137
Medicare Reimbursements		21,947	21,947			0
Dental Plan	33,133	26,196	59,329	143		143
Vision Plan	31,417	26,352	57,769	135		135
Life Insurance	39,286	24,073	63,359	171		171

	CITY & COUNTY OF HONOLULU			C&C BOARD OF WATER SUPPLY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro Plan	7,245	6,159	13,404	454	563	1,017
Medicare Reimbursements		4,056	4,056		445	445
Dental Plan	7,595	6,058	13,653	482	557	1,039
Vision Plan	7,203	6,138	13,341	458	560	1,018
Life Insurance	8,733	5,051	13,784	544	454	998

Revised 2/25/09

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Table 3 – Subscriber Enrollment Count as of June 30, 2008 (continued)

	HAWAII COUNTY			HI COUNTY - DEPT. OF WATER SUPPLY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro Plan	1,920	1,224	3,144	151	80	231
Medicare Reimbursements		736	736		58	58
Dental Plan	1,964	1,192	3,156	155	80	235
Vision Plan	1,895	1,220	3,115	148	80	228
Life Insurance	2,299	1,021	3,320	174	64	238

	MAUI COUNTY			KAUAI COUNTY		
	Active	Retired	Total	Active	Retired	Total
Medical/Drug/Chiro Plan	1,896	1,008	2,904	914	651	1,565
Medicare Reimbursements		661	661		433	433
Dental Plan	1,971	1,001	2,972	944	642	1,586
Vision Plan	1,848	1,010	2,858	908	650	1,558
Life Insurance	2,290	831	3,121	1,138	500	1,638

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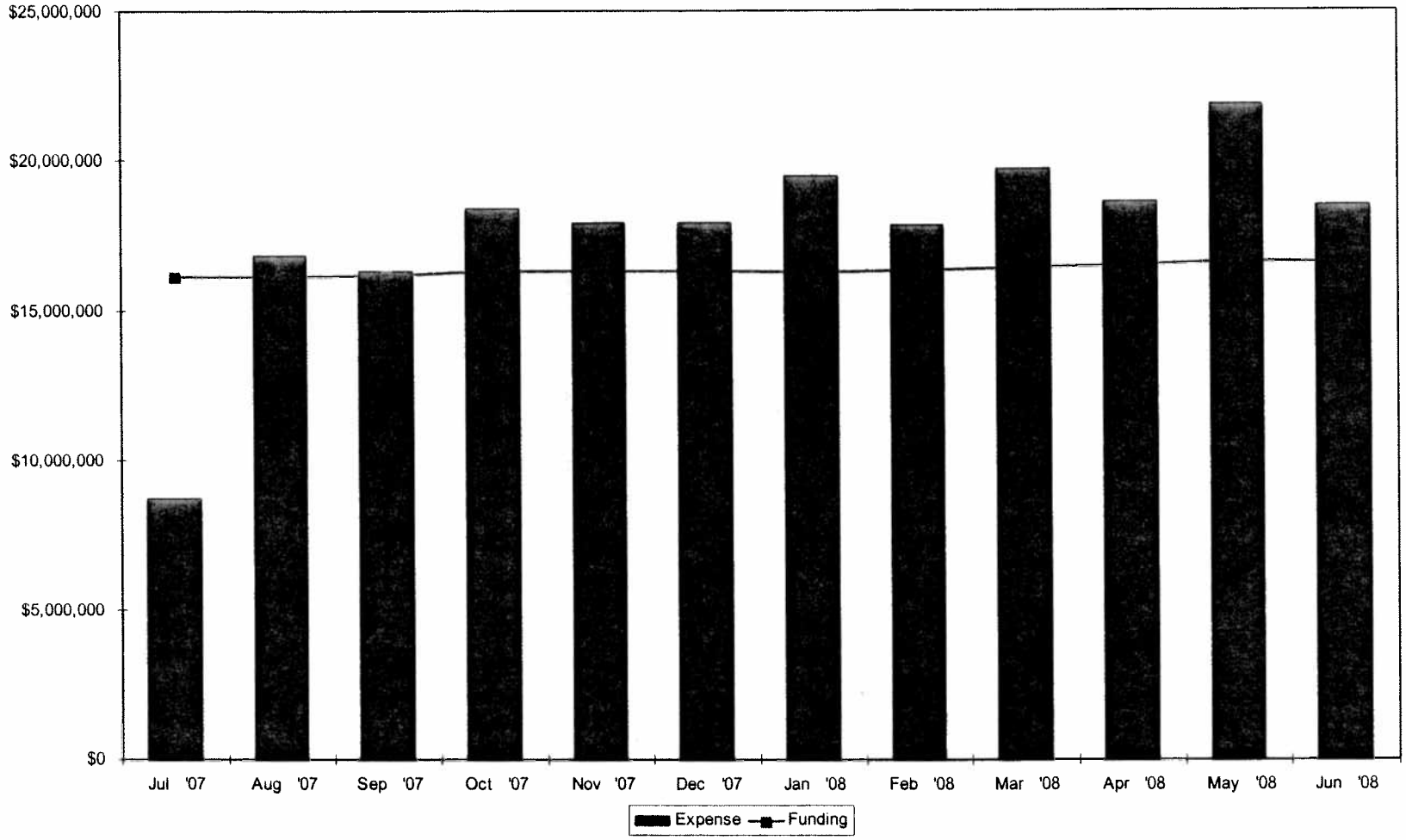
Table 3 – Subscriber Enrollment Count as of June 30, 2008 (continued)

	GRAND TOTAL		
	Active	Retired	Total
Medical/Drug/Chiro Plan	44,082	36,086	80,168
Medicare Reimbursements	0	28,336	28,336
Dental Plan	46,387	35,726	82,113
Vision Plan	44,012	36,010	80,022
Life Insurance	54,635	31,994	86,629

SECTION 3: Self Insured Medical Plans

Expense vs. Funding - Medical/Rx Plan
All Actives



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Expense vs. Funding - Medical/Rx Plan: All Retirees

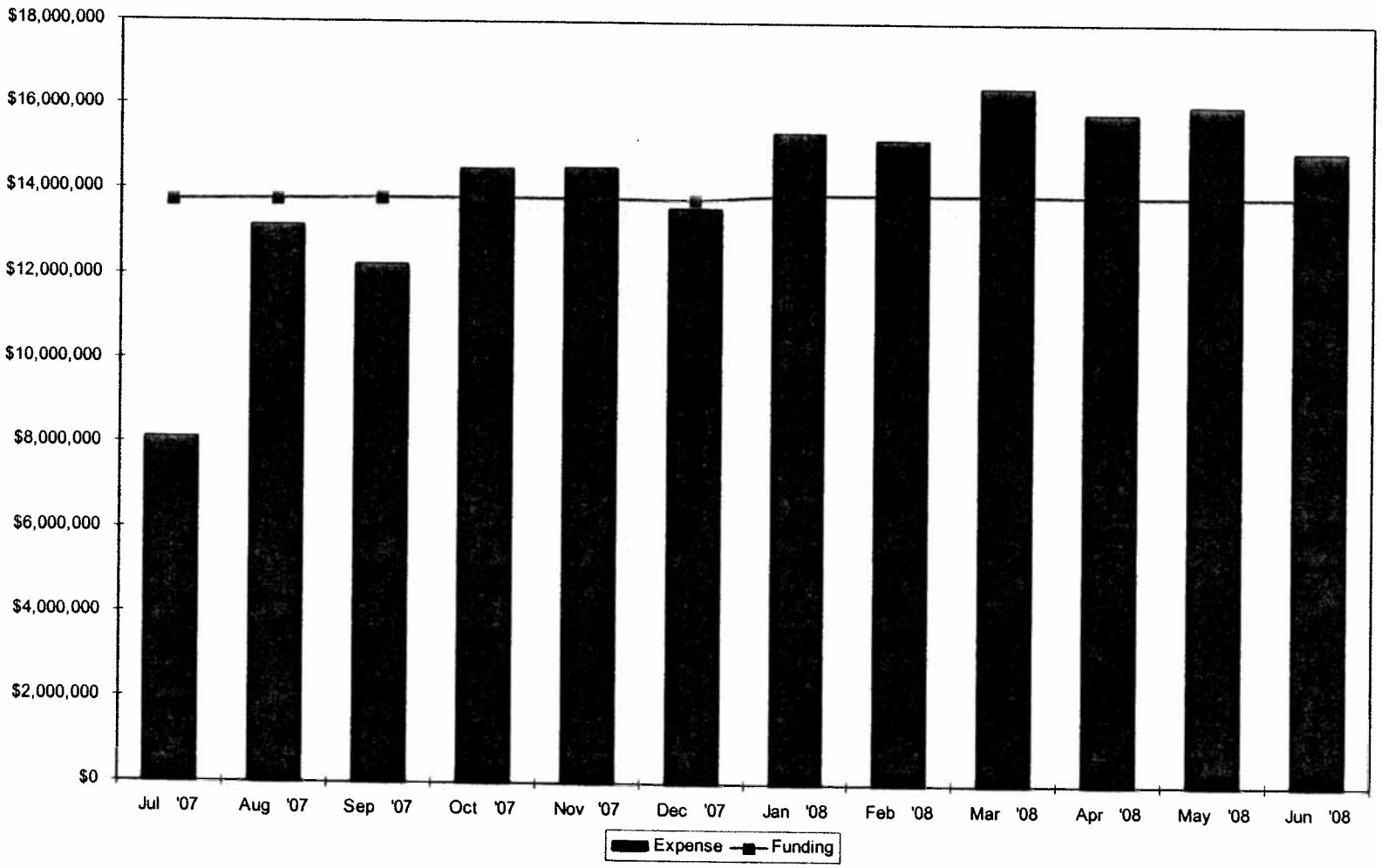

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Table 4 – HMSA Summary of Benefits Paid by Bargaining Unit – Actives PPO

ACTIVE PPO	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$3,937,683.60	$24,111,573.77	$2,635,263.20	$41,909,962.70	$1,917,146.05	$2,531,229.22	$12,409,856.01	$5,336,990.67
Provider Settlements	$461.80	$10,336.71	$0.00	$4,778.22	$62.00	$646.80	$1,837.42	$1,263.75
Quality & Service Recognition Program	$72,106.55	$478,142.22	$46,675.41	$669,645.67	$31,236.04	$52,614.48	$198,427.96	$130,142.37
Subtotal Benefits Paid	$4,010,251.95	$24,600,052.70	$2,681,938.61	$42,584,386.59	$1,948,444.09	$2,584,490.50	$12,610,121.39	$5,468,396.79
Healthpass	$23,952.39	$158,942.50	$15,516.41	$222,569.47	$10,384.66	$17,487.02	$65,943.58	$43,253.59
Mental Health/Substance Abuse Case Mgmt	$10,760.59	$71,387.82	$6,968.97	$99,970.19	$4,664.00	$7,854.60	$29,620.64	$19,428.21
CareConnection	$70,120.38	$465,192.06	$45,412.64	$651,446.40	$30,392.52	$51,183.77	$193,020.13	$126,602.12
Total Benefits Paid	$4,115,085.31	$25,295,575.08	$2,749,836.63	$43,558,372.65	$1,993,885.27	$2,661,015.89	$12,898,705.74	$5,657,680.71
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	($10,060.79)	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$264,098.42	$1,751,333.90	$172,137.72	$2,549,735.00	$119,996.12	$198,127.34	$762,150.14	$506,286.30
Total	$4,379,183.73	$27,046,908.98	$2,921,974.35	$46,098,046.86	$2,113,881.39	$2,859,143.23	$13,660,855.88	$6,163,967.01

Revised 2/25/09

Table 4 – HMSA Summary of Benefits Paid by Bargaining Unit – Actives PPO

ACTIVE PPO	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$4,598,826.70	$10,289,111.36	$5,422,536.69	$8,642,231.52	$25,569,540.89	$2,238,768.76	$0.00	$151,550,721.14
Provider Settlements	$1,398.66	$125.75	$646.80	$713.80	$6,587.97	$582.12	$0.00	$29,441.80
Quality & Service Recognition Program	$80,852.26	$175,939.05	$145,099.91	$241,085.18	$495,741.73	$30,733.24	$0.00	$2,848,442.07
Subtotal Benefits Paid	$4,681,077.62	$10,465,176.16	$5,568,283.40	$8,884,030.50	$26,071,870.59	$2,270,084.12	$0.00	$154,428,605.01
Healthpass	$26,872.56	$58,475.31	$48,226.47	$80,133.02	$164,780.77	$10,234.60	$0.00	$946,772.35
Mental Health/Substance Abuse Case Mgmt	$12,070.22	$26,265.21	$21,661.63	$35,992.30	$74,011.85	$4,594.04	$0.00	$425,250.27
CareConnection	$78,654.46	$171,154.79	$141,155.99	$234,540.46	$482,291.31	$29,936.63	$0.00	$2,771,103.66
Total Benefits Paid	$4,798,674.86	$10,721,071.47	$5,779,327.49	$9,234,696.28	$26,792,954.52	$2,314,849.39	$0.00	$158,571,731.29
HMSA 7/07-6/08 Medical Plan								
Drug Rebate	$0.00	$0.00	($4,201.22)	$0.00	($1,326.70)	$0.00	$0.00	($15,588.71)
ASO Monthly Fee	$300,509.06	$589,132.56	$462,267.82	$767,944.18	$1,845,294.88	$113,808.54	$11,497.52	$10,414,319.50
Total	$5,099,183.92	$11,310,204.03	$6,237,394.09	$10,002,640.46	$28,636,922.70	$2,428,657.93	$11,497.52	$168,970,462.08

Table 5 – HMSA Summary of Benefits Paid by Bargaining Unit – Active Supplemental

ACTIVE-SUPPLEMENTAL	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$100,589.93	$487,962.41	$45,325.24	$629,930.94	$30,818.39	$56,897.98	$83,949.78	$14,549.76
Provider Settlements	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Quality & Service Recognition Program	$1,532.40	$10,941.83	$557.29	$22,140.79	$1,623.13	$1,898.83	$4,037.01	$1,838.18
Subtotal Benefits Paid	$102,122.33	$498,904.24	$45,882.53	$652,071.73	$32,441.52	$58,796.81	$87,986.79	$16,387.94
Healthpass	$509.96	$3,638.41	$185.27	$7,356.21	$539.13	$631.37	$1,341.55	$611.36
Mental Health/Substance Abuse Case Mgmt	$228.96	$1,633.99	$83.21	$3,304.55	$242.21	$283.55	$602.61	$274.54
CareConnection	$1,081.96	$7,721.46	$393.21	$15,615.72	$1,144.57	$1,339.92	$2,847.65	$1,297.34
Total Benefits Paid	$103,943.21	$511,898.10	$46,544.22	$678,348.21	$34,367.43	$61,051.65	$92,778.60	$18,571.18
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$5,155.42	$34,917.40	$1,824.24	$72,153.26	$5,352.56	$6,412.68	$13,410.86	$5,367.52
Total	$109,098.63	$546,815.50	$48,368.46	$750,501.47	$39,719.99	$67,464.33	$106,189.46	$23,938.70

Revised 2/25/09

Table 5 – HMSA Summary of Benefits Paid by Bargaining Unit – Active Supplemental

ACTIVE-SUPPLEMENTAL	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$20,898.03	$139,549.01	$29,182.36	$54,886.51	$310,489.54	$10,566.05	$0.00	$2,015,595.93
Provider Settlements	$43.85	$0.00	$0.00	$0.00	$101.51	$0.00	$0.00	$145.36
Quality & Service Recognition Program	$1,019.51	$3,346.03	$4,604.78	$7,004.70	$11,970.60	$151.99	$0.00	$72,667.07
Subtotal Benefits Paid	$21,961.39	$142,895.04	$33,787.14	$61,891.21	$322,561.65	$10,718.04	$0.00	$2,088,408.36
Healthpass	$338.55	$1,113.01	$1,532.16	$2,329.82	$3,978.96	$50.85	$0.00	$24,156.61
Mental Health/Substance Abuse Case Mgmt	$152.11	$499.79	$687.94	$1,046.22	$1,787.16	$22.79	$0.00	$10,849.63
CareConnection	$718.80	$2,361.77	$3,250.88	$4,943.94	$8,445.26	$107.69	$0.00	$51,270.17
Total Benefits Paid	$23,170.85	$146,869.61	$39,258.12	$70,211.19	$336,773.03	$10,899.37	$0.00	$2,174,684.77
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$3,413.26	$9,911.42	$11,760.06	$18,375.64	$35,860.18	$497.08	($315.60)	$224,095.98
Total	$26,584.11	$156,781.03	$51,018.18	$88,586.83	$372,633.21	$11,396.45	($315.60)	$2,398,780.75

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Table 6 – HMSA Summary of Benefits Paid by Bargaining Unit – Active HDHP

ACTIVE HIGH DEDUCTIBLE HEALTH PLAN	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$504.01	$860.84	$0.00	$1,752.21	$0.00	$0.00	$2,086.22	$10,285.97
Drug Claims Paid	$0.00	$97.05	$0.00	$250.14	$0.00	$0.00	$0.00	$0.00
Provider Settlements	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Quality & Service Recognition Program	$545.86	$220.22	$0.00	$1,192.07	$6.98	$0.00	$1,070.17	$800.73
Subtotal Benefits Paid	$1,049.87	$1,178.11	$0.00	$3,194.42	$6.98	$0.00	$3,156.39	$11,086.70
Healthpass	$181.86	$73.14	$0.00	$394.83	$2.38	$0.00	$354.91	$265.17
Mental Health/Substance Abuse Case Mgmt	$81.62	$32.86	$0.00	$177.55	$1.06	$0.00	$159.53	$119.25
CareConnection	$144.45	$58.15	$0.00	$314.22	$1.88	$0.00	$282.33	$211.04
Rewards Program Benefits Paid	$300.00	$0.00	$0.00	$700.00	$0.00	$0.00	$700.00	$200.00
Total Benefits Paid	$1,757.80	$1,342.26	$0.00	$4,781.02	$12.30	$0.00	$4,653.16	$11,882.16
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HMSA 7/07-6/08 Estimated Drug Program Credit	$0.00	($6.76)	$0.00	($17.42)	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$2,508.16	$841.36	$0.00	$6,249.84	$50.56	$0.00	$5,488.40	$4,183.04
Total	$4,265.96	$2,176.86	$0.00	$11,013.44	$62.86	$0.00	$10,141.56	$16,065.20

Revised 2/25/09

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Table 6 – HMSA Summary of Benefits Paid by Bargaining Unit – Active HDHP

ACTIVE HIGH DEDUCTIBLE HEALTH PLAN	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$125.35	$0.00	$0.00	$12,104.47	$8,063.56	$0.00	$0.00	$35,782.63
Drug Claims Paid	$0.00	$0.00	$0.00	$0.00	$255.96	$0.00	$0.00	$603.15
Provider Settlements	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Quality & Service Recognition Program	$46.81	$35.62	$135.26	$316.25	$1,474.99	$0.00	$0.00	$5,844.96
Subtotal Benefits Paid	$172.16	$35.62	$135.26	$12,420.72	$9,794.51	$0.00	$0.00	$42,230.74
Healthpass	$15.23	$11.78	$44.78	$104.97	$489.41	$0.00	$0.00	$1,938.46
Mental Health/Substance Abuse Case Mgmt	$6.89	$5.30	$20.14	$47.17	$219.95	$0.00	$0.00	$871.32
CareConnection	$12.19	$9.38	$35.64	$83.48	$389.26	$0.00	$0.00	$1,542.02
Rewards Program Benefits Paid	$0.00	$0.00	$0.00	$0.00	$1,600.00	$0.00	$0.00	$3,500.00
Total Benefits Paid	$206.47	$62.08	$235.82	$12,656.34	$12,493.13	$0.00	$0.00	$50,082.54
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HMSA 7/07-6/08 Estimated Drug Program Credit	$0.00	$0.00	$0.00	$0.00	($17.82)	$0.00	$0.00	($42.00)
ASO Monthly Fee	$217.88	$167.60	$636.88	$1,297.24	$6,452.36	$0.00	$334.64	$28,427.96
Total	$424.35	$229.68	$872.70	$13,953.58	$18,927.67	$0.00	$334.64	$78,468.50

Revised 2/25/09

Table 7 – HMSA Summary of Benefits Paid by Bargaining Unit – Active HMO

ACTIVE HMO PLAN	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$142,470.08	$1,420,074.24	$66,181.66	$2,151,485.50	$33,454.98	$67,074.60	$304,192.43	$326,732.15
Drug Claims Paid	$35,776.65	$181,058.34	$28,223.75	$402,639.26	$15,029.38	$16,271.32	$50,437.57	$45,573.51
Provider Settlements	($26.21)	($76.89)	$0.00	$974.75	$0.00	($33.09)	($47.37)	($45.41)
HMO Health Center Costs	$5,088.80	$23,044.16	$1,331.93	$39,884.03	$1,529.49	$1,407.98	$8,216.81	$9,362.15
Subtotal Benefits Paid	$183,309.32	$1,624,099.85	$95,737.34	$2,594,983.54	$50,013.85	$84,720.81	$362,799.44	$381,622.40
Healthpass	$855.37	$3,996.43	$264.28	$6,703.12	$237.32	$321.00	$1,363.31	$1,585.61
Mental Health/Substance Abuse Case Mgmt	$540.60	$2,602.83	$182.85	$4,294.59	$155.29	$200.87	$885.10	$985.80
CareConnection	$2,288.58	$11,018.83	$774.08	$18,180.74	$657.41	$850.36	$3,746.99	$4,173.29
Total Benefits Paid	$186,993.87	$1,641,717.94	$96,958.55	$2,624,161.99	$51,063.87	$86,093.04	$368,794.84	$388,367.10
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($1,326.72)	$0.00
HMSA 7/07-6/08 Estimated Drug Program Credit	($2,490.05)	($12,601.66)	($1,964.37)	($28,023.68)	($1,046.04)	($1,132.48)	($3,510.45)	($3,171.92)
ASO Monthly Fee	$16,572.86	$80,175.54	$5,625.44	$137,479.30	$4,768.60	$5,728.12	$28,451.76	$33,003.90
Total	$201,076.68	$1,709,291.82	$100,619.62	$2,733,617.61	$54,786.43	$90,688.68	$392,409.43	$418,199.08

Revised 2/25/09

Table 7 – HMSA Summary of Benefits Paid by Bargaining Unit – Active HMO

ACTIVE HMO PLAN	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$250,824.71	$449,087.68	$191,039.25	$153,332.44	$1,040,194.39	$23,643.40	$0.00	$6,619,787.51
Drug Claims Paid	$46,347.99	$65,990.08	$25,467.49	$31,973.80	$255,541.71	$4,956.97	$0.00	$1,205,287.82
Provider Settlements	($6.31)	($25.39)	($6.66)	($44.43)	($131.39)	($1.01)	$0.00	$530.59
HMO Health Center Costs	$3,329.42	$7,284.97	$5,165.25	$6,203.38	$23,149.86	$391.53	$0.00	$135,389.76
Subtotal Benefits Paid	$300,495.81	$522,337.34	$221,665.33	$191,465.19	$1,318,754.57	$28,990.89	$0.00	$7,960,995.68
Healthpass	$808.95	$1,441.65	$1,096.63	$1,063.35	$4,118.16	$85.22	$0.00	$23,940.40
Mental Health/Substance Abuse Case Mgmt	$505.62	$905.24	$699.07	$679.46	$2,632.51	$45.58	$0.00	$15,315.41
CareConnection	$2,140.49	$3,832.25	$2,959.45	$2,876.43	$11,144.48	$192.96	$0.00	$64,836.34
Total Benefits Paid	$303,950.87	$528,516.48	$226,420.48	$196,084.43	$1,336,649.72	$29,314.65	$0.00	$8,065,087.83
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($1,326.72)
HMSA 7/07-6/08 Estimated Drug Program Credit	($3,225.82)	($4,592.91)	($1,772.54)	($2,225.38)	($17,785.70)	($345.00)	$0.00	($83,888.00)
ASO Monthly Fee	$15,587.22	$25,857.04	$20,957.72	$19,809.90	$80,767.08	$1,450.42	$11,456.34	$487,691.24
Total	$316,312.27	$549,780.61	$245,605.66	$213,668.95	$1,399,631.10	$30,420.07	$11,456.34	$8,467,564.35

Table 8 – HMSA Summary of Benefits Paid by Bargaining Unit – Retiree (Non-Medicare) PPO

RETIREE WITHOUT MEDICARE PPO	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$3,165,970.74	$5,133,156.19	$1,822,237.06	$6,266,277.48	$661,817.24	$1,198,492.46	$825,485.08	$311,644.48
Provider Settlements	$216.60	$1,149.49	$0.00	$864.14	$0.00	$0.00	$88.65	$0.00
Quality & Service Recognition Program	$71,891.95	$63,543.63	$12,877.10	$91,467.69	$11,619.68	$16,294.85	$15,219.87	$6,611.77
Subtotal Benefits Paid	$3,238,079.29	$5,197,849.31	$1,835,114.16	$6,358,609.31	$673,436.92	$1,214,787.31	$840,793.60	$318,256.25
Healthpass	$23,896.03	$21,113.37	$4,277.88	$30,395.29	$3,860.28	$5,414.37	$5,058.49	$2,195.11
Mental Health/Substance Abuse Case Mgmt	$10,733.03	$9,484.35	$1,921.78	$13,653.33	$1,734.16	$2,432.17	$2,272.11	$986.33
CareConnection	$129,037.56	$114,025.34	$23,104.55	$164,146.78	$20,848.89	$29,240.70	$27,316.38	$11,858.13
Total Benefits Paid	$3,401,745.91	$5,342,472.37	$1,864,418.37	$6,566,804.71	$699,880.25	$1,251,874.55	$875,440.58	$333,295.82
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$296,231.78	$278,823.66	$58,881.92	$415,001.14	$52,506.40	$75,241.68	$65,758.38	$30,554.02
Total	$3,697,977.69	$5,621,296.03	$1,923,300.29	$6,981,805.85	$752,386.65	$1,327,116.23	$941,198.96	$363,849.84

Table 8 – HMSA Summary of Benefits Paid by Bargaining Unit – Retiree (Non-Medicare) PPO

RETIREE WITHOUT MEDICARE PPO	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$527,530.13	$1,477,270.92	$2,441,609.75	$4,907,115.67	$4,780,520.22	$113,151.03	$0.00	$37,728,377.99
Provider Settlements	$0.00	$132.00	$646.80	$1,717.66	$6,040.78	$0.00	$0.00	$11,161.12
Quality & Service Recognition Program	$8,183.17	$16,856.00	$52,609.67	$77,934.85	$71,523.28	$1,522.53	$0.00	$594,164.25
Subtotal Benefits Paid	$535,713.30	$1,494,258.92	$2,494,866.22	$4,986,768.18	$4,858,084.28	$114,673.56	$0.00	$38,333,703.36
Healthpass	$2,719.83	$5,602.54	$17,486.05	$25,897.17	$23,760.82	$506.29	$0.00	$197,480.53
Mental Health/Substance Abuse Case Mgmt	$1,221.65	$2,516.44	$7,854.07	$11,632.97	$10,674.20	$227.37	$0.00	$88,701.33
CareConnection	$14,687.25	$30,253.83	$94,425.34	$139,857.06	$128,330.28	$2,733.55	$0.00	$1,066,409.31
Total Benefits Paid	$554,342.03	$1,532,631.73	$2,614,631.68	$5,164,155.38	$5,020,849.58	$118,140.77	$0.00	$39,686,294.53
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$38,855.82	$71,654.72	$216,358.12	$308,236.72	$316,901.52	$5,851.56	($9,280.60)	$2,572,426.98
Total	$593,197.85	$1,604,286.45	$2,830,989.80	$5,472,392.10	$5,337,751.10	$123,992.33	($9,280.60)	$42,258,721.51

Revised 2/25/09

Table 9 – HMSA Summary of Benefits Paid by Bargaining Unit – Retiree (Medicare) PPO

RETIREE WITH MEDICARE PPO	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Medical Claims Paid	$6,528,765.45	$6,592,017.14	$1,317,636.98	$7,213,788.76	$687,979.09	$778,673.48	$1,906,783.66	$450,214.74
Provider Settlements	$0.00	$0.00	$0.00	$19.60	$0.00	$0.00	$0.00	$414.05
Quality & Service Recognition Program	$227,979.51	$210,166.40	$35,785.58	$260,679.08	$25,987.68	$27,312.96	$62,078.04	$11,000.53
Subtotal Benefits Paid	$6,756,744.96	$6,802,183.54	$1,353,422.56	$7,474,487.44	$713,966.77	$805,986.44	$1,968,861.70	$461,629.32
Healthpass	$75,792.25	$69,862.02	$11,897.68	$86,636.34	$8,637.32	$9,075.50	$20,629.48	$3,653.43
Mental Health/Substance Abuse Case Mgmt	$34,040.31	$31,378.12	$5,343.46	$38,914.72	$3,879.60	$4,076.76	$9,266.52	$1,641.41
CareConnection	$227,410.92	$209,625.80	$35,697.71	$259,975.09	$25,918.20	$27,235.35	$61,906.25	$10,965.66
Total Benefits Paid	$7,093,988.44	$7,113,049.48	$1,406,361.41	$7,860,013.59	$752,401.89	$846,374.05	$2,060,663.95	$477,889.82
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$1,032,639.36	$1,124,971.66	$196,436.88	$1,377,020.44	$142,907.96	$138,225.44	$336,547.40	$58,050.94
Total	$8,126,627.80	$8,238,021.14	$1,602,798.29	$9,237,034.03	$895,309.85	$984,599.49	$2,397,211.35	$535,940.76

Revised 2/25/09

Table 9 – HMSA Summary of Benefits Paid by Bargaining Unit – Retiree (Medicare) PPO

RETIREE WITH MEDICARE PPO	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premium	TOTAL
Medical Claims Paid	$777,555.91	$1,293,307.16	$758,075.97	$869,176.61	$3,953,249.57	$24,714.60	$0.00	$38,133,775.21
Provider Settlements	$0.00	$0.00	$0.00	$646.80	$0.00	$0.00	$0.00	$1,065.90
Quality & Service Recognition Program	$25,967.46	$33,929.33	$22,577.14	$20,162.18	$135,805.92	$719.27	$0.00	$1,287,534.19
Subtotal Benefits Paid	$803,523.37	$1,327,236.49	$780,653.11	$889,985.59	$4,089,055.49	$25,433.87	$0.00	$39,422,375.30
Healthpass	$8,630.06	$11,276.93	$7,501.40	$6,699.16	$45,121.30	$239.77	$0.00	$427,921.83
Mental Health/Substance Abuse								
Case Mgmt	$3,876.42	$5,065.21	$3,369.74	$3,009.34	$20,269.32	$107.59	$0.00	$192,209.27
CareConnection	$25,896.95	$33,838.82	$22,512.01	$20,104.31	$135,411.95	$718.77	$0.00	$1,284,080.19
Total Benefits Paid	$841,926.80	$1,377,417.45	$814,036.26	$919,798.40	$4,289,858.06	$26,500.00	$0.00	$41,326,586.59
HMSA 7/07-6/08 Medical Plan Drug Rebate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ASO Monthly Fee	$131,023.42	$173,947.12	$124,432.10	$115,961.38	$729,327.28	$2,797.34	($24,209.96)	$6,622,412.82
Total	$972,950.22	$1,551,364.57	$938,468.36	$1,035,759.78	$5,019,185.34	$29,297.34	($24,209.96)	$47,948,999.41

Table 10 – HMA Benefits Paid by Plan by Bargaining Unit by Tier

EUTF ACTIVES

	Elected / Appointed & Other Excluded	Hawaii Fire Fighters Association (HFFA)	Hawaii Government Employees Association	State of Hawaii Organization of Police	United Public Workers (UPW)	University of Hawaii Professional Assembly	Grand Total
Single	11,128.91	1,065.38	472,404.06	676.73	32,882.17	120,651.21	638,808.46
2-Party	7,341.56	2,259.05	201,201.08	60,071.22	133,473.24	28,418.21	432,764.36
Family	36,122.86	15,996.20	294,175.66	28,924.79	462,182.17	8,785.58	846,187.26
Grand Total	54,593.33	19,320.63	967,780.80	89,672.74	628,537.58	157,855.00	1,917,760.08

RETIREES - NON-MEDICARE

	Elected / Appointed & Other Excluded	Hawaii Fire Fighters Association (HFFA)	Hawaii Government Employees Association (HGEA)	State of Hawaii Organization of Police Officers	United Public Workers (UPW)	Grand Total
Single						
2-Party	773.10		31,249.04	21,657.07	52.43	53,731.64
Family		295.28			1,044.10	1,339.38
Grand Total	773.10	295.28	31,249.04	21,657.07	1,096.53	55,071.02

RETIREES - MEDICARE

	Elected / Appointed & Other Excluded	Hawaii Government Employees Association (HGEA)	United Public Workers (UPW)	Grand Total
Single	203.08	14,054.05		14,257.13
2-Party	471.02	1,443.28	12,009.91	13,924.21
Family				
Grand Total	674.10	15,497.33	12,009.91	28,181.34

Revised 2/25/09

SECTION 4: Self Insured Prescription Drug Plan

Table 11: Hawaii EUTF - Plan Performance

	Jul 07 - Jun 08		
	Actives	Early Retirees	Actives & Early Retirees
Average Eligible Members	70,464	16,266	86,730
Utilizing Members %	53.4%	68.0%	56.0%
Average Age	36	54	39
Total Rx Cost	$54,547,192	$23,581,493	$78,128,685
Average Rx Cost	$71.86	$75.06	$72.80
Brand	$132.87	$128.57	$131.51
Generic	$34.01	$34.59	$34.17
Dispensing Fee/Rx	$1.80	$1.65	$1.76
Member Paid	$8,302,146	$3,350,916	$11,653,062
Member Paid %	15.2%	14.2%	14.9%
Plan Paid	$46,245,045	$20,230,577	$66,475,622
Plan Paid %	84.8%	85.8%	85.1%
Total Prescriptions	759,094	314,164	1,073,258
Generic Dispensing Rate	61.7%	56.9%	60.3%
Generic Substitution Rate	96.7%	95.6%	96.4%
Rxs PMPM	0.90	1.61	1.03
Rx Cost PMPM	$64.51	$120.81	$75.07
Member Paid PMPM	$9.82	$17.17	$11.20
Plan Paid PMPM	$54.69	$103.64	$63.87

Revised 2/25/09

Table 12: Hawaii EUTF (Actives) - Plan Performance

	3Q07	4Q07	1Q08	2Q08	Jul 07 - Jun 08
Average Eligible Members	70,001	70,344	70,315	71,197	70,464
Utilizing Members %	51.4%	52.8%	55.1%	54.3%	53.4%
Average Age	35	36	36	36	36
Total Rx Cost	$12,450,219	$13,462,530	$14,152,614	$14,481,829	$54,547,192
Average Rx Cost	$70.50	$71.17	$71.90	$73.71	$71.86
Brand	$126.37	$129.17	$135.17	$140.78	$132.87
Generic	$32.85	$33.66	$34.40	$34.91	$34.01
Dispensing Fee/Rx	$1.87	$1.80	$1.78	$1.77	$1.80
Member Paid	$1,938,580	$2,087,749	$2,133,919	$2,141,898	$8,302,146
Member Paid %	15.6%	15.5%	15.1%	14.8%	15.2%
Plan Paid	$10,511,639	$11,374,780	$12,018,695	$12,339,931	$46,245,045
Plan Paid %	84.4%	84.5%	84.9%	85.2%	84.8%
Total Prescriptions	176,593	189,170	196,850	196,481	759,094
Generic Dispensing Rate	59.7%	60.7%	62.8%	63.4%	61.7%
Generic Substitution Rate	96.5%	96.8%	96.4%	97.1%	96.7%
Rxs PMPM	0.84	0.90	0.93	0.92	0.90
Rx Cost PMPM	$59.29	$63.79	$67.09	$67.80	$64.51
Member Paid PMPM	$9.23	$9.89	$10.12	$10.03	$9.82
Plan Paid PMPM	$50.05	$53.90	$56.98	$57.77	$54.69

Revised 2/25/09

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Table 13: Hawaii EUTF (Early Retirees) - Plan Performance

	3Q07	4Q07	1Q08	2Q08	Jul 07 - Jun 08
Average Eligible Members	17,202	15,847	15,963	16,052	16,266
Utilizing Members %	66.4%	70.1%	68.3%	67.3%	68.0%
Average Age	55	54	54	54	54
Total Rx Cost	$5,966,857	$5,732,872	$5,882,219	$5,999,545	$23,581,493
Average Rx Cost	$74.23	$73.93	$74.96	$77.16	$75.06
Brand	$124.63	$124.75	$129.66	$135.94	$128.57
Generic	$33.35	$33.91	$35.41	$35.64	$34.59
Dispensing Fee/Rx	$1.79	$1.66	$1.59	$1.57	$1.65
Member Paid	$887,575	$823,428	$818,462	$821,451	$3,350,916
Member Paid %	14.9%	14.4%	13.9%	13.7%	14.2%
Plan Paid	$5,079,282	$4,909,444	$5,063,757	$5,178,094	$20,230,577
Plan Paid %	85.1%	85.6%	86.1%	86.3%	85.8%
Total Prescriptions	80,388	77,548	78,475	77,753	314,164
Generic Dispensing Rate	55.2%	55.9%	58.0%	58.6%	56.9%
Generic Substitution Rate	95.4%	95.9%	95.2%	95.8%	95.6%
Rxs PMPM	1.56	1.63	1.64	1.61	1.61
Rx Cost PMPM	$115.62	$120.59	$122.83	$124.59	$120.81
Member Paid PMPM	$17.20	$17.32	$17.09	$17.06	$17.17
Plan Paid PMPM	$98.42	$103.27	$105.74	$107.53	$103.64

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Table 14: Hawaii EUTF - Retail vs. Mail Utilization

	Jul 07 - Jun 08					
	Actives		Early Retiree		Active & Early Retiree	
	Retail	Mail	Retail	Mail	Retail	Mail
Total Prescriptions	725,623	33,471	289,514	24,650	1,015,137	58,121
% of Total Prescriptions	95.6%	4.4%	92.2%	7.8%	94.6%	5.4%
Average Rx Cost	$66.43	$189.54	$66.87	$171.31	$66.55	$181.80
Average Member Paid	$10.36	$23.47	$9.66	$22.44	$10.16	$23.04
Average Plan Paid	$56.07	$166.06	$57.20	$148.86	$56.39	$158.77
Member Paid %	15.6%	12.4%	14.5%	13.1%	15.3%	12.7%
Plan Paid %	84.4%	87.6%	85.5%	86.9%	84.7%	87.3%

Please note: Participants may obtain up to a 90 day supply of a prescription via NMHC Mail and retail pharmacy, however a lower copayment applies for prescriptions obtained through mail service.

Table 15: Hawaii EUTF - Specialty Drug Summary

	July 2007 through June 2008		
	Actives	Early Retirees	Actives + Early Retirees
# of Claims	**1,918**	**714**	2,632
Average Plan Cost/Claim	**$907.69**	**$861.46**	$895.15
Specialty Plan Spend	**$1,740,945**	**$615,085**	$2,356,030
% of Plan Cost	**3.8%**	**3.0%**	3.5%
Top Specialty Drugs in terms of Plan Cost	**Revlimid Tarceva Cellcept Tracleer Gleevec**	**Gleevec Tarceva Cellcept Thalomid**	

Note: The EUTF Traditional plan currently does not cover injectable medications with the exception of a few (i.e. Symlin, Byetta, Insulin, Glucagon, Imitrex injection and epinephrine injections).

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Table 16: Medicare Rx Plan - Plan Performance

	3Q07	4Q07	1Q08	2Q08	Jul 07 - Jun 08
Average Eligible Members	26,406	28,049	28,317	28,414	27,797
Utilizing Members %	87.5%	88.8%	89.4%	89.5%	88.8%
Total Rx Cost	$16,228,586	$19,024,893	$20,039,403	$20,335,104	$75,627,987
Average Rx Cost	$77.19	$82.50	$83.94	$84.81	$82.26
Brand	$132.51	$139.61	$147.46	$150.81	$142.69
Generic	$30.11	$36.09	$36.46	$37.29	$35.20
Dispensing Fee/Rx	$1.87	$1.86	$1.86	$1.85	$1.86
Member Paid	$2,554,530	$2,799,616	$2,847,179	$2,855,343	$11,056,669
Member Paid %	15.7%	14.7%	14.2%	14.0%	14.6%
Plan Paid	$13,674,057	$16,225,277	$17,192,224	$17,479,761	$64,571,318
Plan Paid %	84.3%	85.3%	85.8%	86.0%	85.4%
Plan Paid (adjusted*) %	56.9%	60.8%	65.4%	65.4%	62.4%
Total Prescriptions	210,251	230,600	238,740	239,760	919,351
Generic Dispensing Rate	54.0%	55.2%	57.2%	58.1%	56.2%
Generic Substitution Rate	95.2%	96.1%	96.4%	95.7%	95.9%
Rxs PMPM	2.65	2.74	2.81	2.81	2.76
Rx Cost PMPM	$204.86	$226.09	$235.89	$238.56	$226.73
Member Paid PMPM	$32.25	$33.27	$33.52	$33.50	$33.15
Plan Paid PMPM	$172.61	$192.82	$202.38	$205.06	$193.58
Plan Paid PMPM (adjusted*)	$116.53	$137.43	$154.22	$155.97	$141.48

*Adjusted for credits issued by CMS for 7/07 thru 6/08. Total credit = $17,379,753.50.

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Table 17: Medicare Rx Plan - Retail vs. Mail Utilization

	Jul 07 - Jun 08	
	Retail	Mail
Total Prescriptions	821,748	97,603
% of Total Prescriptions	89.4%	10.6%
Average Rx Cost	$71.46	$173.18
Average Member Paid	$10.79	$22.44
Average Plan Paid	$60.67	$150.74
Member Paid %	15.1%	13.0%
Plan Paid %	84.9%	87.0%

*Not adjusted for CMS credits

Please note: Participants may obtain up to a 90 day supply of a prescription via NMHC Mail and retail pharmacy, however a lower copayment applies for prescriptions obtained through mail service.

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Table 18: Medicare Rx Plan - Specialty Drug Summary

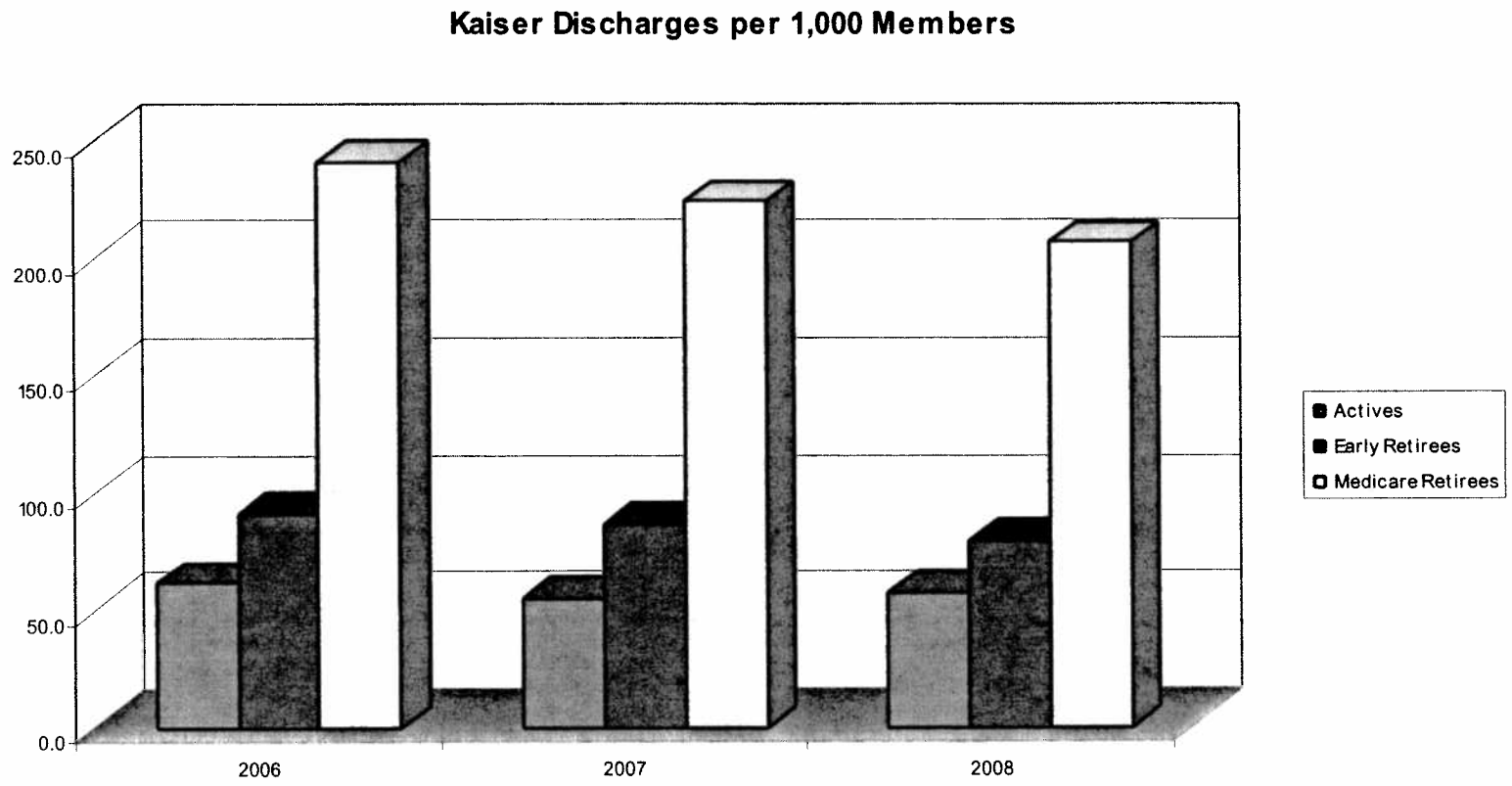
	All Specialty
Number of Claims	**2,460**
Average Plan Cost/Claim	**$1,090.49**
Specialty Plan Spend	**$2,682,613**
% of Total Plan Cost	**4.1%**
Top Specialty Drugs in terms of Plan Cost	**Tarceva Enbrel Thalomid Gleevec Revlimid Sensipar Forteo**

SECTION 5: Fully Insured Medical Plans

Table 19 – Kaiser Medical Frequency Rates by Type of Service

	Actives				Retirees w/o Medicare				Retirees w/ Medicare			
	Plan Year			%	Plan Year			%	Plan Year			%
	2006	2007	2008	Change	2006	2007	2008	Change	2006	2007	2008	Change
OUTPATIENT												
Outpatient Visits	106,285	93,854	103,854	9.4%	18,523	21,012	21,878	4.7%	58,935	69,678	75,587	10.0%
Laboratory Procedures	124,296	106,223	103,901	-1.9%	33,549	34,952	34,515	-1.3%	117,202	113,690	117,784	3.5%
Radiology Procedures	16,951	13,904	13,882	-0.1%	4,000	3,905	3,784	-3.0%	12,085	12,084	12,277	1.6%
INPATIENT												
Discharges per 1,000 Members	61.1	54.6	57.5	4.6%	91.4	86.3	79.6	-7.3%	240.8	224.0	206.4	-7.3%
Hospital Days per 1,000 Members	311.7	274.9	262.8	-3.9%	828.6	592.4	657.6	7.9%	2,025.4	2,151.5	1,755.3	-19.6%

Kaiser Inpatient Utilization



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Kaiser Inpatient Utilization

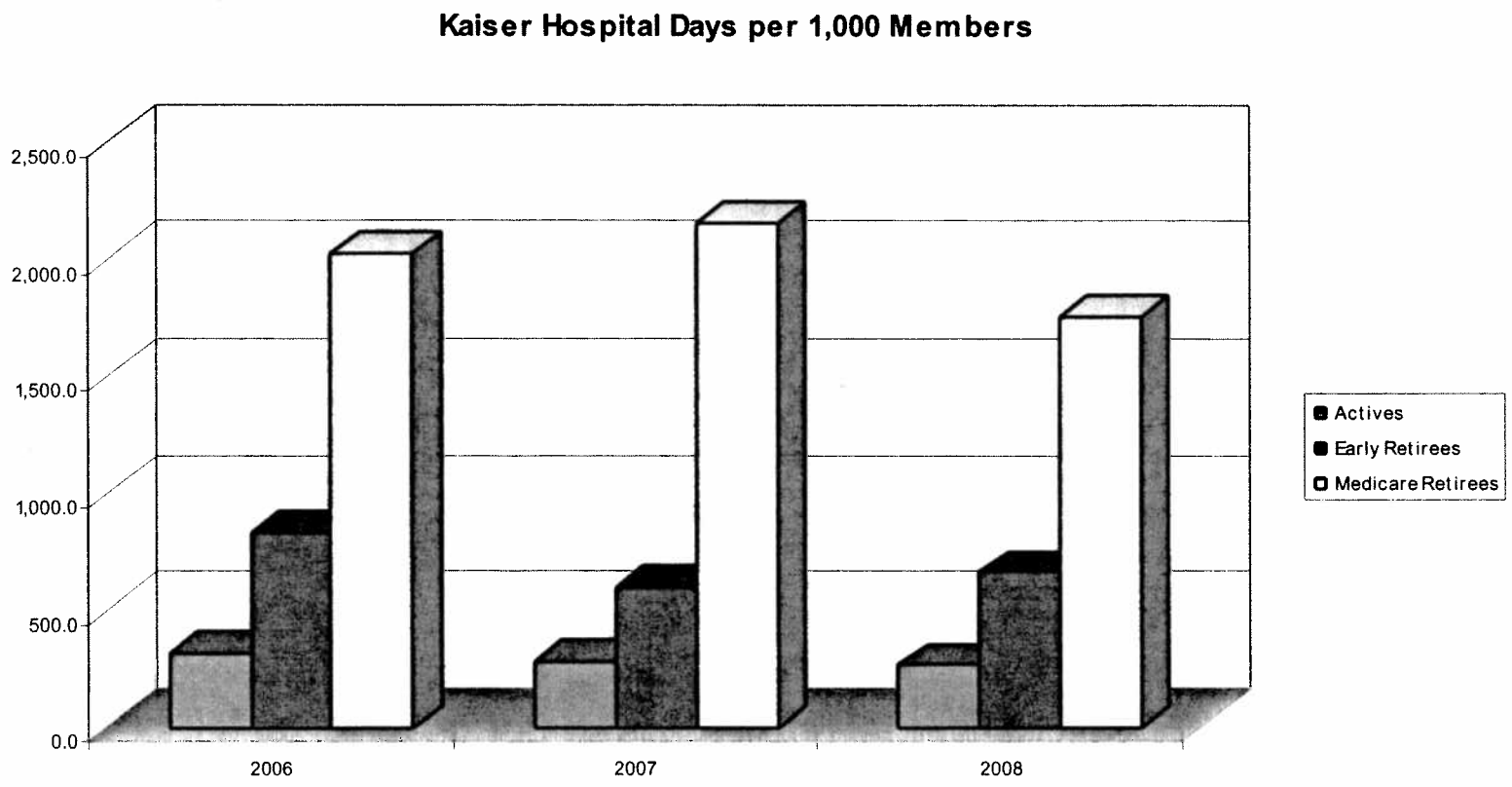

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Table 20 – Kaiser Utilization by Bargaining Unit

	COBRA	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HGEA	UHPA
	00	00	01	02	03	04	06	07
Outpatient Utilization								
Outpatient Visits	908	1,939	19,894	1,605	25,352	1,152	1,107	9,997
Per Member Per Year	8.44	6.60	5.48	5.57	6.37	6.46	5.43	6.17
- % change fr. Prior Year	6.2%	27.2%	18.4%	19.0%	17.5%	26.9%	14.6%	17.1%
Avg. Cost per Visit	$248.29	$176.62	$162.58	$214.75	$165.45	$140.70	$167.84	$168.02
- % change fr. Prior Year	27.3%	-4.8%	-8.5%	38.1%	-8.8%	-6.4%	15.1%	4.8%
Laboratory Procedures	759	1,798	21,803	2,204	27,344	1,458	1,156	10,168
Per Member Per Year	7.06	6.12	6.00	7.65	6.87	8.18	5.67	6.27
- % change fr. Prior Year	-30.6%	9.9%	7.7%	5.4%	4.6%	50.9%	16.2%	11.2%
Radiology Procedures	146	262	2,683	243	3,600	182	168	1,524
Per Member Per Year	1.36	0.89	0.74	0.85	0.91	1.02	0.82	0.94
- % change fr. Prior Year	28.3%	20.3%	5.7%	13.3%	8.3%	27.5%	12.3%	17.5%
Inpatient Utilization								
Total Discharges per 1,000 Members	111.63	98.72	55.07	72.92	65.62	56.13	49.04	46.9
Total Hospital Days Per 1,000 Members	725.58	255.32	334.30	319.44	378.63	319.93	127.50	256.09
- % change fr. Prior Year	79.7%	9.7%	13.1%	28.0%	-23.7%	7.3%	-37.4%	136.8%

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Table 20 – Kaiser Utilization by Bargaining Unit (continued)

	HGEA 08	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	TOTAL
Outpatient Utilization							
Outpatient Visits	3,546	3,941	10,143	3,629	5,784	14,194	**103,191**
Per Member Per Year	5.00	6.36	5.66	4.84	5.07	6.25	**5.87**
- % change fr. Prior Year	4.4%	22.3%	19.2%	20.1%	23.7%	13.8%	**17.4%**
Avg. Cost per Visit	$162.20	$129.55	$160.46	$124.35	$152.12	$161.36	**$161.87**
- % change fr. Prior Year	-3.1%	-24.5%	-12.9%	-18.3%	-8.9%	-11.3%	**-7.8%**
Laboratory Procedures	3,187	3,719	9,085	2,174	4,364	14,682	**103,901**
Per Member Per Year	4.49	6.00	5.07	2.90	3.83	6.46	**5.91**
- % change fr. Prior Year	-4.9%	0.5%	-2.9%	-10.2%	-5.2%	8.4%	**4.4%**
Radiology Procedures	482	504	1,156	401	606	1,817	**13,774**
Per Member Per Year	0.68	0.81	0.65	0.54	0.53	0.8	**0.78**
- % change fr. Prior Year	-1.4%	-8.0%	1.6%	3.8%	6.0%	-2.4%	**5.4%**
Inpatient Utilization							
Total Discharges per 1,000 Members	53.55	75.83	58.64	26.68	56.15	44.03	**57**
Total Hospital Days Per 1,000 Members	147.96	198.44	189.88	53.36	224.59	129.45	**262.83**
- % change fr. Prior Year	15.3%	16.1%	5.8%	-57.9%	62.2%	-45.6%	**-4.4%**

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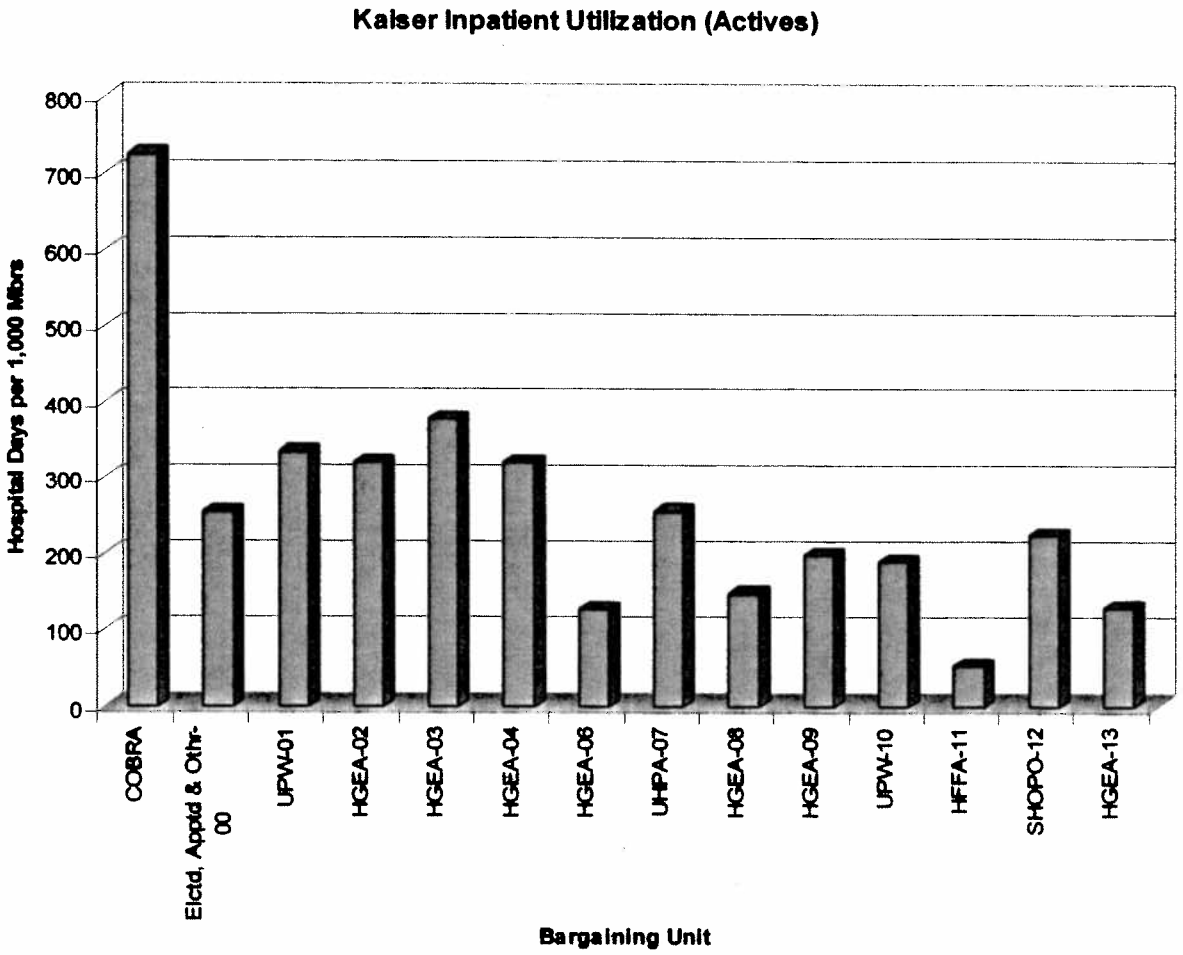
Kaiser Utilization by Bargaining Unit



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Kaiser Utilization by Bargaining Unit (continued)

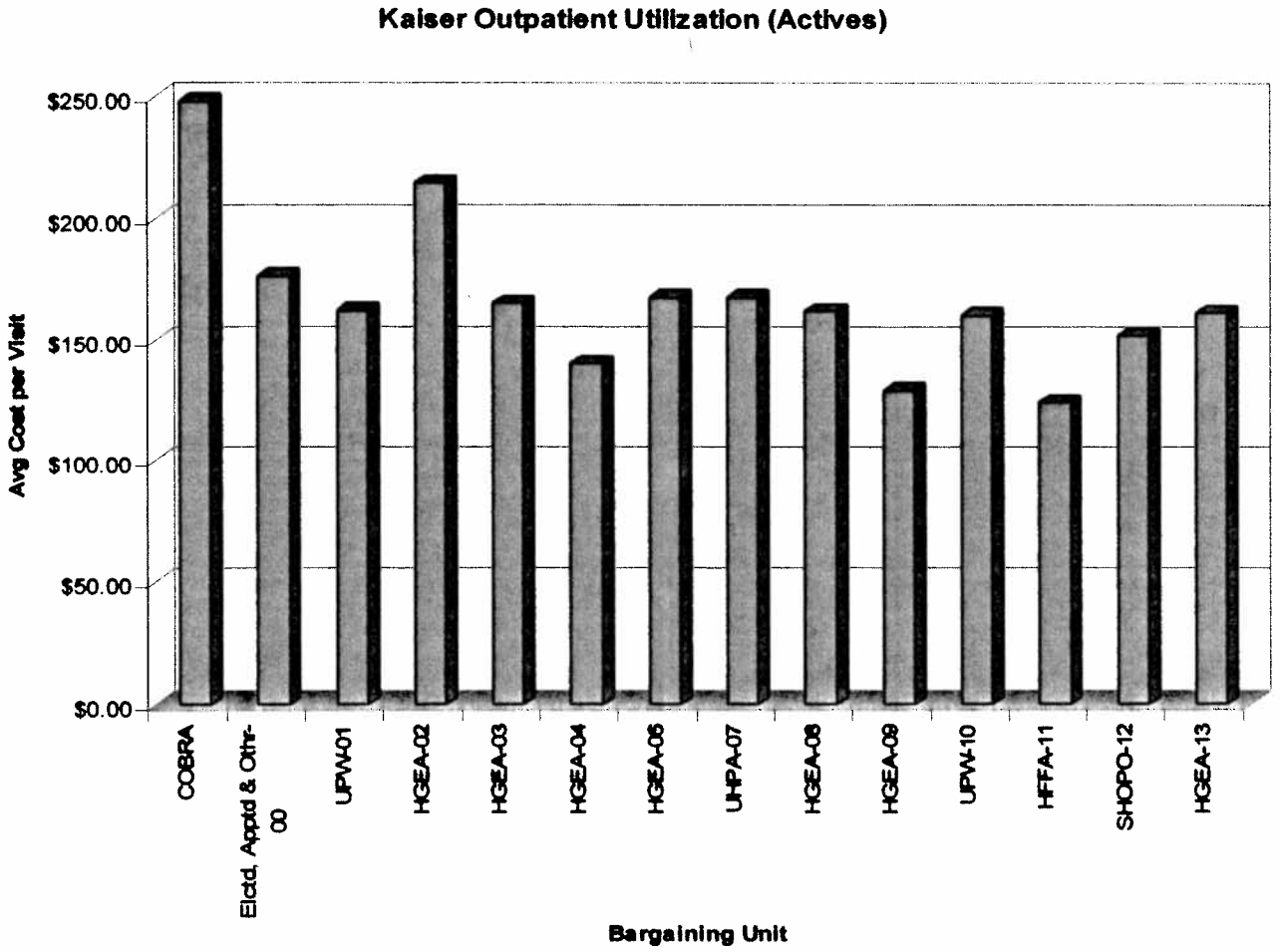

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Table 21 – Kaiser Retiree Utilization

	Early Retirees	Medicare Retirees
Outpatient Utilization		
Outpatient Visits	22,055	75,785
Per Member Per Year	7.41	11.52
- % change fr. Prior Year	7.4%	7.6%
Avg. Cost per Visit	$197.74	$201.12
- % change fr. Prior Year	-9.0%	-6.9%
Laboratory Procedures	34,515	117,784
Per Member Per Year	11.6	17.91
- % change fr. Prior Year	1.1%	2.5%
Radiology Procedures	3,827	12,267
Per Member Per Year	1.29	1.87
- % change fr. Prior Year	0.8%	0.5%
Inpatient Utilization		
Total Discharges per 1,000 Members	79.64	206.36
Total Hospital Days Per 1,000 Members	657.59	1,755.34
- % change fr. Prior Year	11.0%	-18.4%

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Table 22 – Royal State Supplemental Health Plan Financial Results

	FY08 Active Participants	FY07 Active Participants
Dues Income	$ 619,610	$ 632,520
Less Claims	$ (136,045)	$ (431,192)
Less IBNR	$ (328,663)	$ (107,275)
Incurred Claims	$ (464,708)	$ (538,467)
Less Retention	$ (92,942)	$ (94,878)
Total (Deficit)/Surplus	**$ 61,960**	**$ (825)**

Table 25 – Royal State Supplemental Health3 Plan Financial Results by Bargaining Unit

	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HGEA	UHPA	HGEA	HGEA	UPW	HFFA	SHOPO	HGEA	COBRA	TOTAL
	00	01	02	03	04	06	07	08	09	10	11	12	13	78	
Dues Income	$ 6,264	$ 63,032	$ 15,056	$ 285,104	$ 10,170	$ 7,902	$ 6,898	$ 18,662	$ 13,098	$ 18,832	$ 21,601	$ 23,229	$ 129,762	$ -	$ 619,610
Less Claims	$ (1,820)	$ (18,620)	$ (8,175)	$ (114,109)	$ (3,378)	$ (3,500)	$ (3,056)	$ (9,500)	$ (3,275)	$ (5,104)	$ (9,018)	$ (5,552)	$ (47,506)	$ (18,252)	$ (250,865)
Less IBNR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Less Retention	$ (940)	$ (9,455)	$ (2,258)	$ (42,766)	$ (1,526)	$ (1,185)	$ (1,035)	$ (2,799)	$ (1,965)	$ (2,825)	$ (3,240)	$ (3,484)	$ (19,464)	$ -	$ (92,942)
															$ -
Total (Deficit)/Surplus	$ 3,504	$ 34,957	$ 4,623	$ 128,229	$ 5,266	$ 3,217	$ 2,807	$ 6,363	$ 7,858	$ 10,903	$ 9,343	$ 14,193	$ 62,792	$ (18,252)	$ 275,803
% of (Deficit)/Surplus	55.94%	55.46%	30.71%	44.98%	51.78%	40.71%	40.69%	34.10%	59.99%	57.90%	43.25%	61.10%	48.39%		

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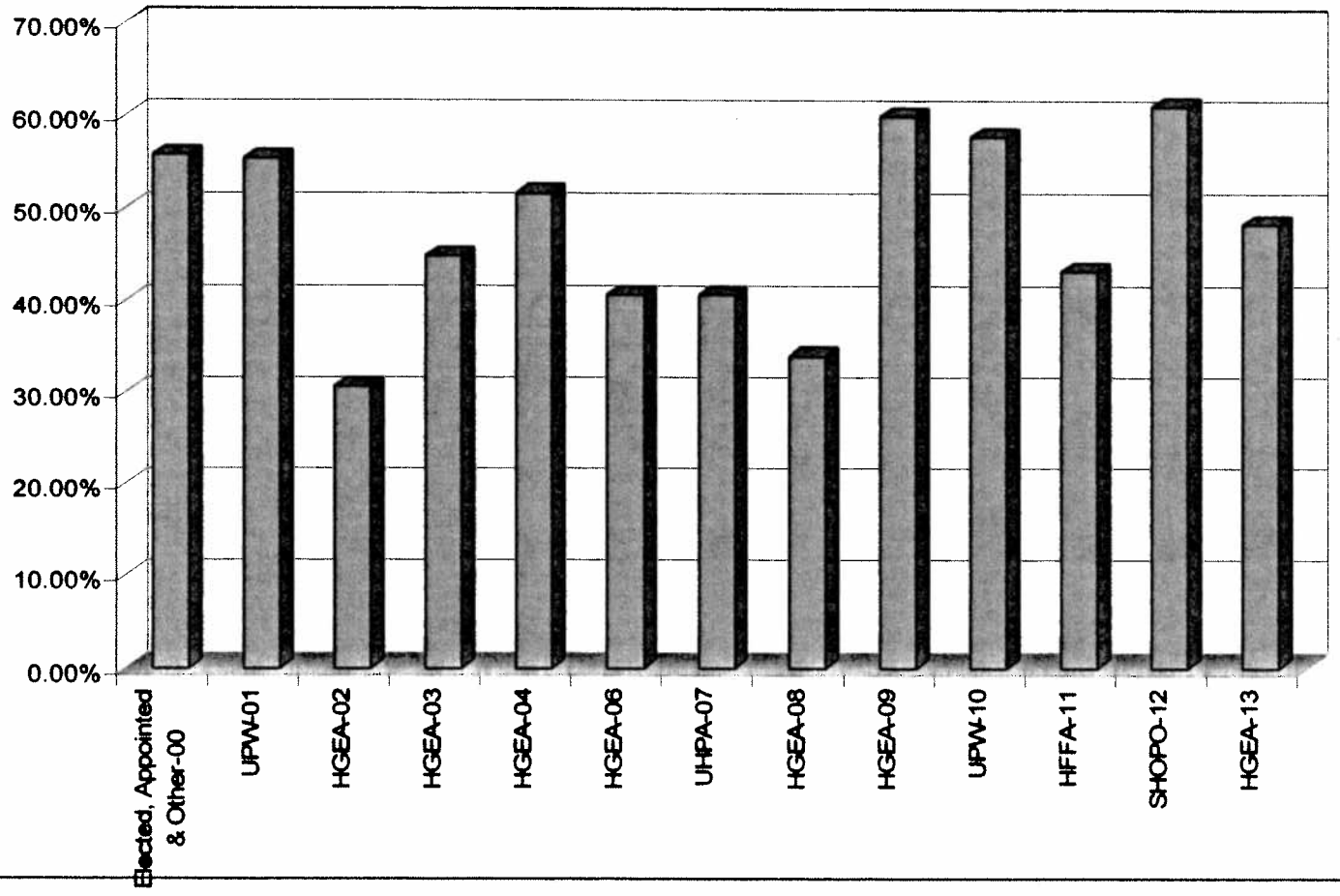
Royal State Supplemental Health Plan Financial Operations for FY08 - % of (Deficit)/Surplus



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SECTION 6: Chiropractic Plan

Table 24 – RSN Chiropractic Plan Financial Results

	FY 2008 Active Participants	FY 2007 Active Participants
Dues Income	$ 1,099,535	$ 1,035,489
Less Claims & Capitation Fees	$ (915,320)	$ (882,358)
Less IBNR	$ -	$ -
Less Retention	$ (164,930)	$ (155,322)
Total (Deficit)/Surplus	**$ 19,285**	**$ (2,191)**

Table 25 – RSN Chiropractic Plan Financial Results by Bargaining Unit

	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HGEA	UHPA
	00	01	02	03	04	06	07
Dues Income	$ 27,187	$ 191,753	$ 17,494	$ 283,946	$ 12,921	$ 18,702	$ 83,834
Less Claims*	$ (22,606)	$ (159,551)	$ (14,563)	$ (236,723)	$ (10,750)	$ (15,566)	$ (69,766)
Less IBNR	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Less Retention	$ (4,078)	$ (28,763)	$ (2,624)	$ (42,592)	$ (1,938)	$ (2,805)	$ (12,575)
Total (Deficit)/Surplus	$ 503	$ 3,439	$ 307	$ 4,631	$ 233	$ 331	$ 1,493
% of (Deficit)/Surplus	1.85%	1.79%	1.75%	1.63%	1.80%	1.77%	1.78%

	HGEA	HGEA	UPW	HFFA	SHOPO	**TOTAL**
	08	09	10	11	12	
Dues Income	$ 56,604	$ 32,379	$ 67,298	$ 45,861	$ 73,040	$ 635,837
Less Claims*	$ (47,035)	$ (26,948)	$ (56,007)	$ (38,177)	$ (60,810)	$ (529,525)
Less IBNR	$ -	$ -	$ -	$ -	$ -	$ -
Less Retention	$ (8,491)	$ (4,857)	$ (10,095)	$ (6,879)	$ (10,956)	$ (95,375)
						$ -
Total (Deficit)/Surplus	$ 1,078	$ 574	$ 1,196	$ 805	$ 1,274	$ 10,937
% of (Deficit)/Surplus	1.90%	1.77%	1.78%	1.76%	1.74%	

* includes capitation fees

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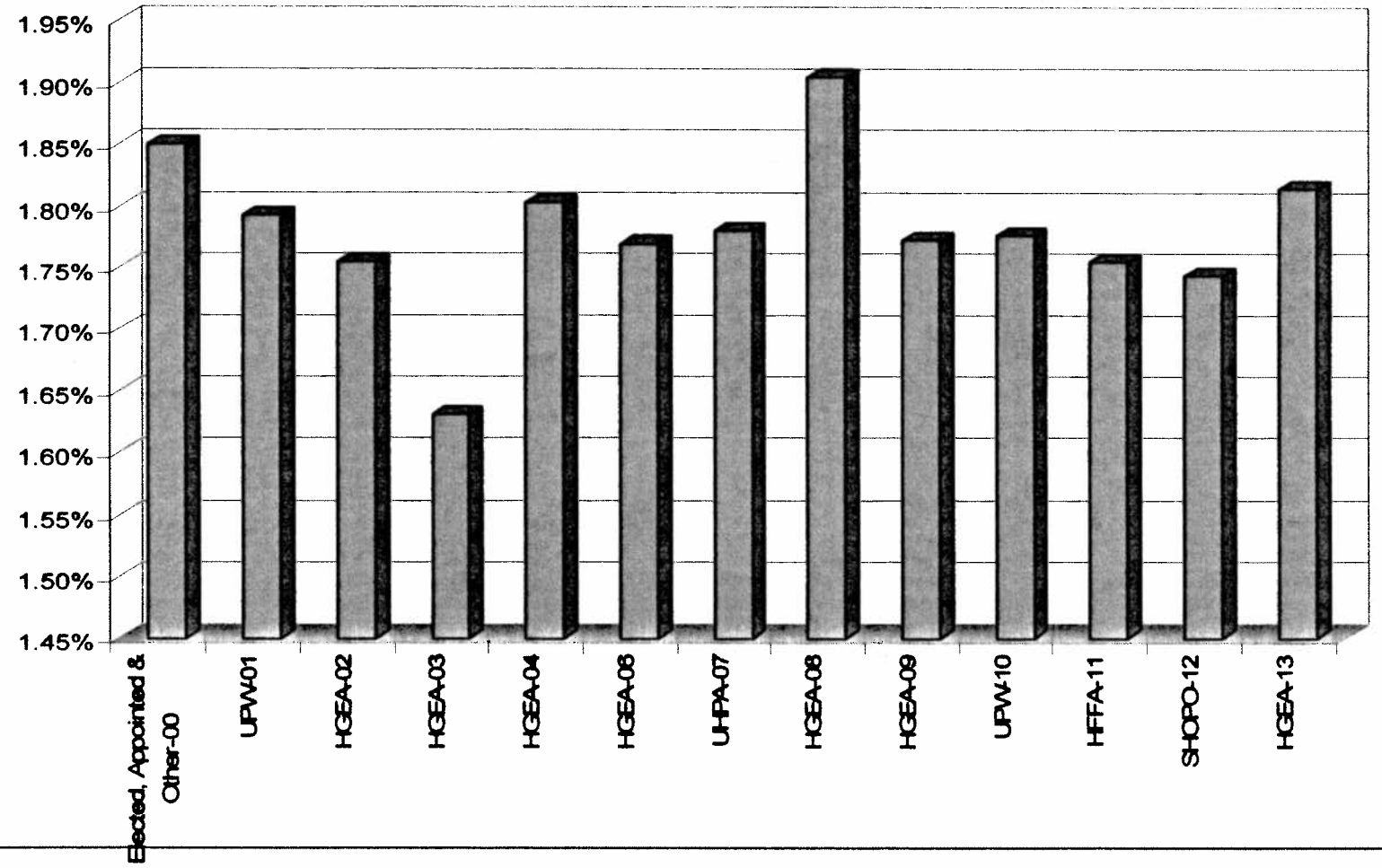
Chiropractic Plan Financial Operations for FY08 - % of (Deficit)/Surplus



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SECTION 7: Dental Plans

Table 26 – HDS Dental Financial Results

	Actives - Regular	Retirees
Dues Income	$ 29,682,001	$ 16,943,979
Less Claims	$ (28,906,974)	$ (16,238,921)
Less IBNR	$ (94,451)	$ (51,940)
Less Retention	$ (1,641,951)	$ (853,842)
Total (Deficit)/Surplus	**$ (961,375)**	**$ (200,724)**

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HDS Dental Financial Results

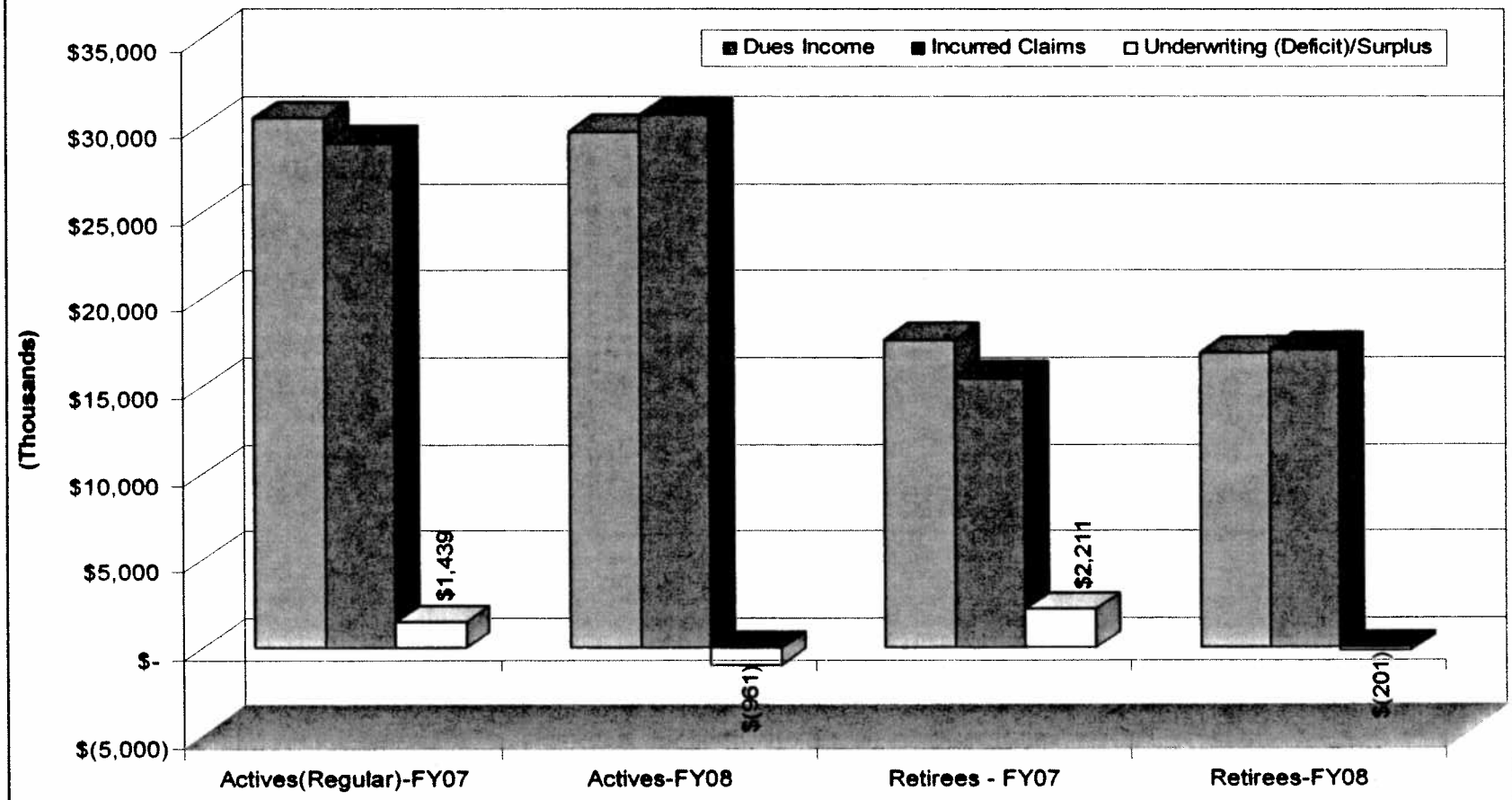

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Table 27 – Dental Plan Enrollment
Monthly Average

	Grand Total		Total Actives			Actives - Regular			Actives - Dual			Total Retirees		
Plan Year Ending	Average Enrolled	% change from Prior Year	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total
2004	85,744	N/A	51,929	N/A	60.6%	50,114	N/A	58.4%	1,815	N/A	2.1%	33,815	N/A	39.4%
2005	87,205	1.7%	52,452	1.0%	60.1%	50,743	1.3%	58.2%	1,709	-5.8%	2.0%	34,753	2.8%	39.9%
2006	85,234	-2.3%	49,526	-5.6%	58.1%	48,017	-5.4%	56.3%	1,509	-11.7%	1.8%	35,708	2.7%	41.9%
2007	78,247	-8.2%	42,782	-13.6%	50.2%	42,782	-10.9%	50.2%	0	-100.0%	0.0%	35,465	-0.7%	41.6%
2008	80,022	2.3%	44,012	2.9%	51.6%	44,012	2.9%	51.6%				36,010	1.5%	42.2%

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Dental Plan Enrollment
Monthly Average

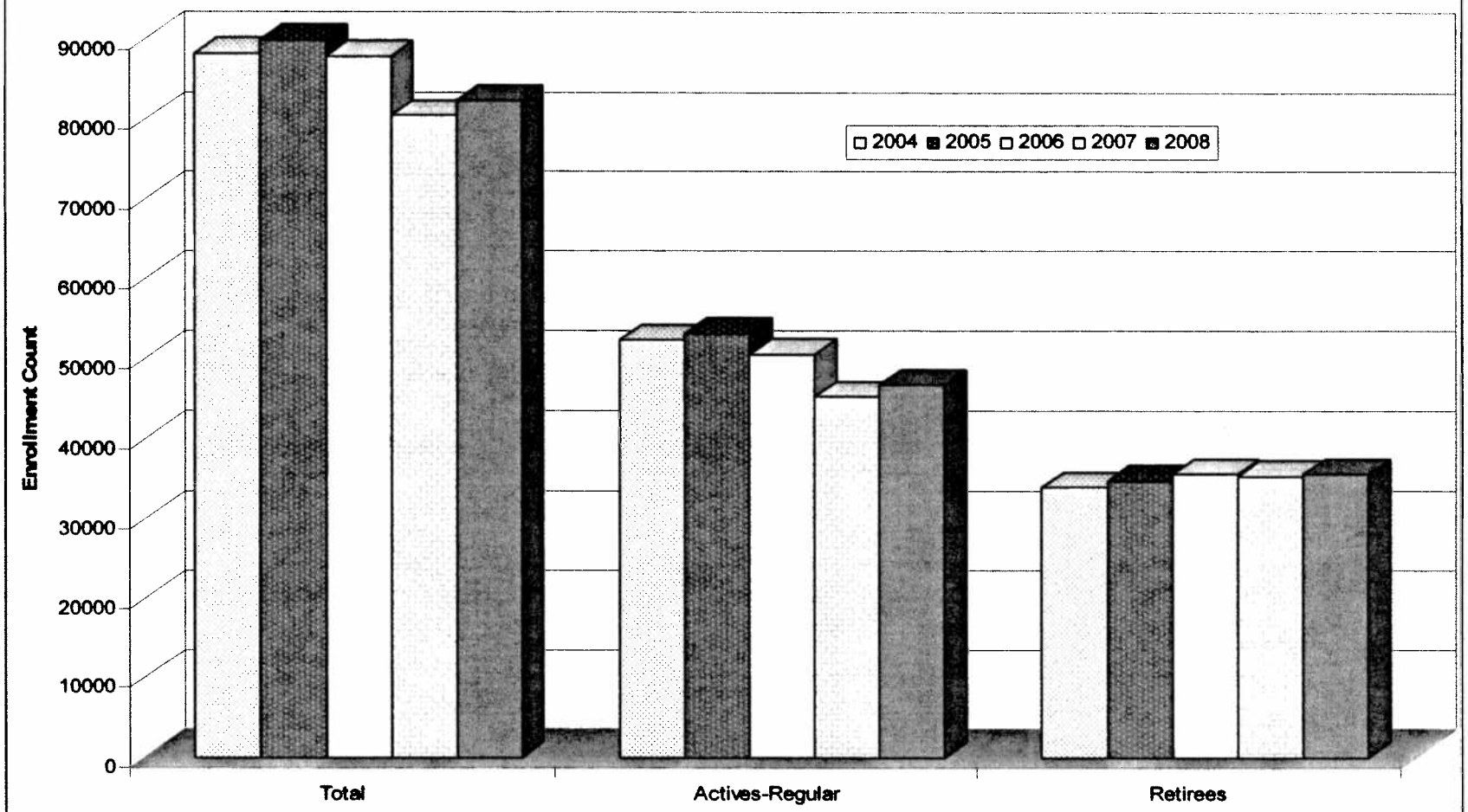

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Table 28– Monthly Average Dental Plan Enrollment by Tier – 2008 Plan Year

	Average Enrolled	% of Grand Total
Actives		
Single	22,059	
Two Party	8,852	
Family	15,700	
Total	46,611	56.7%
Retirees		
Single	20,539	
Two Party	13,333	
Family	1,707	
Total	35,579	43.3%
Grand Total		
Single	42,598	51.8%
Two Party	22,185	27.0%
Family	17,407	21.2%
Total	82,190	100.0%

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Monthly Average Dental Plan Enrollment by Tier – 2008 Plan Year

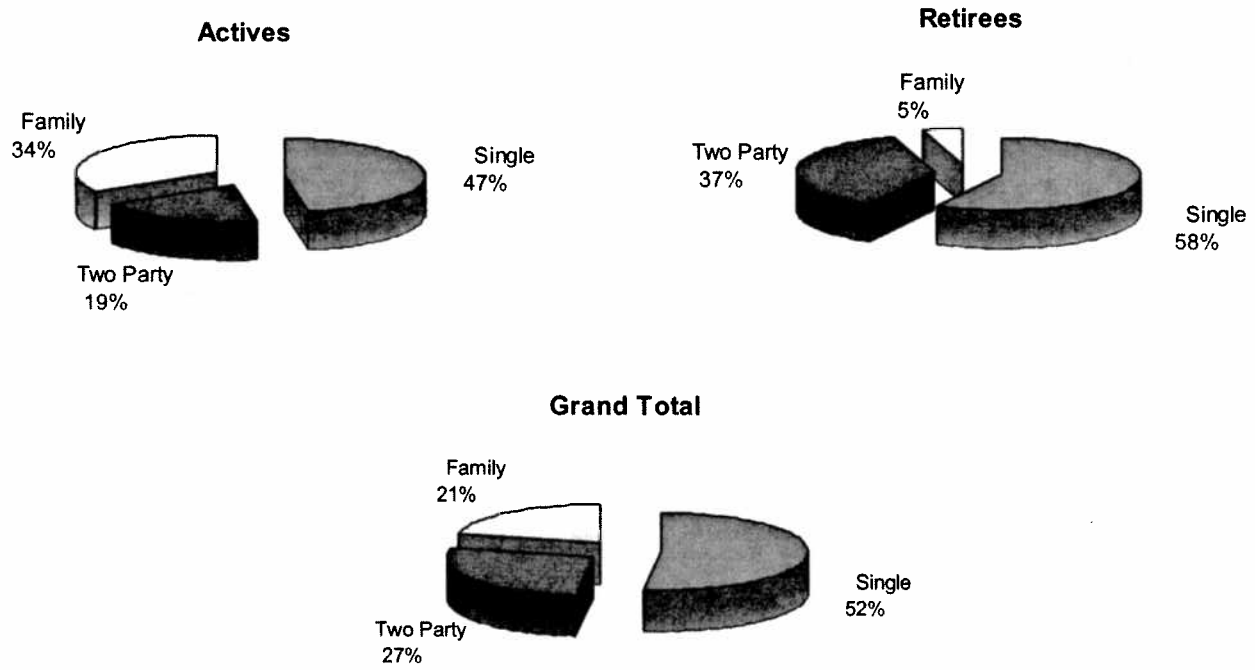

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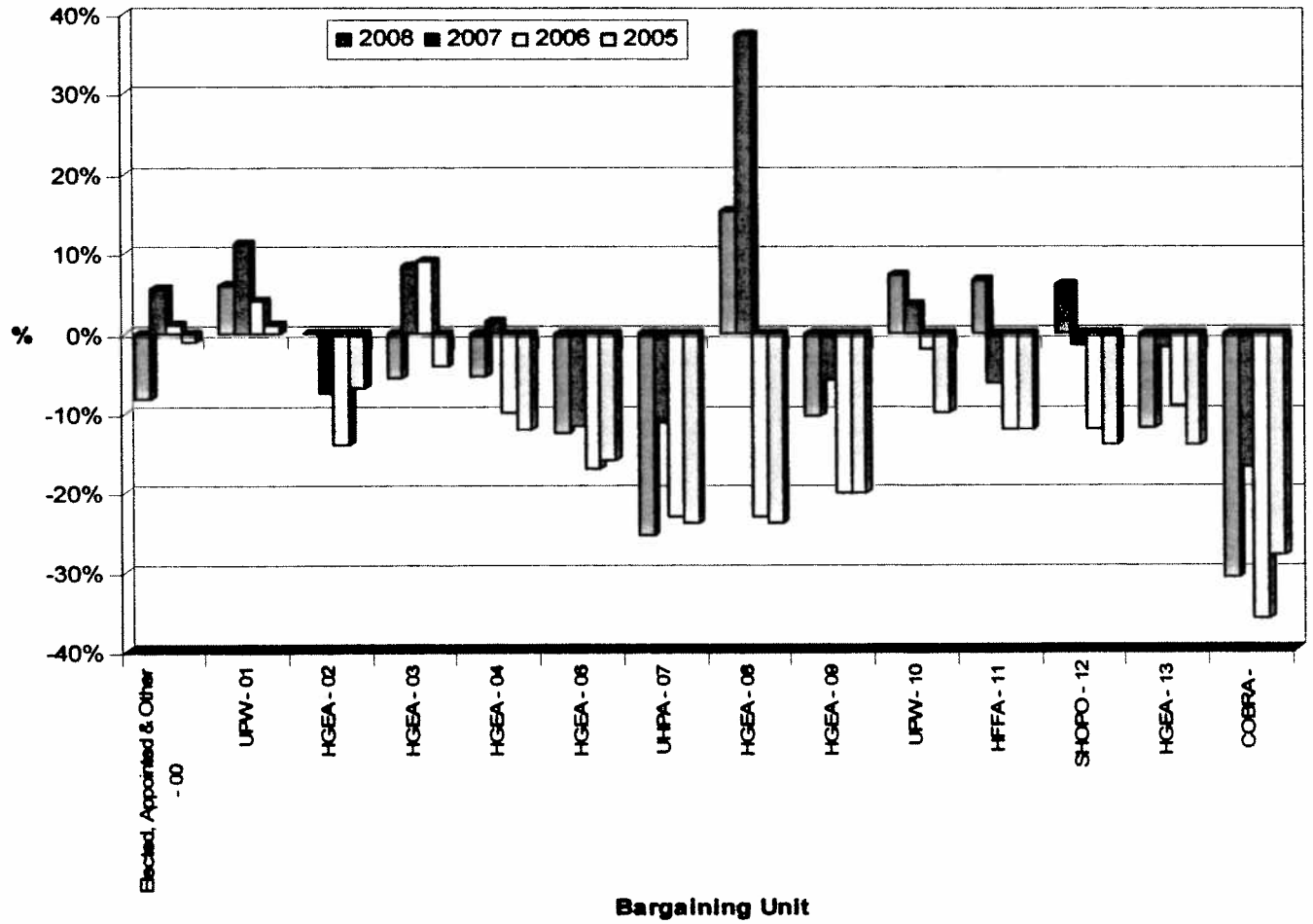
Table 29 – HDS Financial Results by Bargaining Unit

Actives - Regular Plan	Elected, Appointed & Other 00	UPW 01	HGEA 02	HGEA 03	HGEA 04	HGEA 06	UHPA 07	HGEA 08
Dues Income	$ 740,208	$ 5,028,865	$ 463,084	$ 7,727,471	$ 366,646	$ 492,171	$ 2,128,358	$ 1,303,989
Less Claims*	$(753,917)	$(4,435,984)	$ (438,533)	$(7,679,995)	$ (365,192)	$(526,026)	$(2,542,219)	$ (1,013,425)
Less IBNR	$ (2,463)	$ (14,494)	$ (1,433)	$ (25,094)	$ (1,193)	$ (1,719)	$ (8,306)	$ (3,311)
Less Retention	$ (43,704)	$ (271,851)	$ (23,417)	$ (450,139)	$ (20,003)	$ (26,024)	$ (118,729)	$ (88,621)
Total (Deficit)/Surplus	$ (59,876)	$ 306,536	$ (298)	$ (427,757)	$ (19,742)	$ (61,599)	$ (540,897)	$ 198,632
% of (Deficit)/Surplus	-8.1%	6.1%	-0.1%	-5.5%	-5.4%	-12.5%	-25.4%	15.2%

Actives - Regular Plan	HGEA 09	UPW 10	HFFA 11	SHOPO 12	HGEA 13	COBRA	Retro Premiums & Run-off	**TOTAL**
Dues Income	$ 854,903	$ 1,856,427	$ 1,295,244	$ 2,014,364	$ 5,054,052	$ 275,955	$ 80,265	$ 29,682,002
Less Claims*	$(895,874)	$(1,621,837)	$(1,146,512)	$(1,793,590)	$(5,358,891)	$(334,979)		$(28,906,974)
Less IBNR	$ (2,927)	$ (5,299)	$ (3,746)	$ (5,860)	$ (17,510)	$ (1,095)		$ (94,451)
Less Retention	$ (44,557)	$ (91,264)	$ (59,719)	$ (91,765)	$ (282,376)	$ (24,756)	$ (5,028)	$ (1,641,951)
Total (Deficit)/Surplus	$ (88,455)	$ 138,027	$ 85,266	$ 123,149	$ (604,725)	$ (84,873)	$ 75,237	$ (961,373)
% of (Deficit)/Surplus	-10.3%	7.4%	6.6%	6.1%	-12.0%	-30.8%	93.7%	-3.2%

HDS Financial Results by Bargaining Unit - % Deficit/Surplus



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HDS Claims by Service Type – Actives Plan

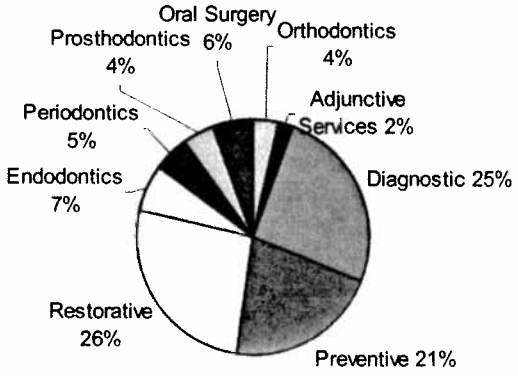
July 1, 2006 through June 30, 2007

Service Type	# of Procedures	Amount Paid
Diagnostic	206,530	$ 6,979,868
Preventive	112,110	$ 5,686,601
Restorative	73,768	$ 7,214,745
Endodontics	7,592	$ 1,774,901
Periodontics	10,417	$ 1,286,182
Prosthodontics	4,095	$ 1,223,685
Oral Surgery	12,471	$ 1,524,107
Orthodontics	7,497	$ 973,020
Adjunctive Services	7,973	$ 536,604
Sub-Total	442,453	$ 27,199,713
Less Adjustments		$ (82,370)
Total		**$ 27,117,343**

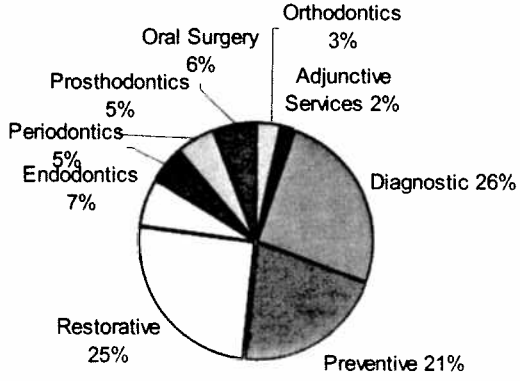
July 1, 2007 through June 30, 2008

Service Type	# of Procedures	Amount Paid
Diagnostic	207,168	$ 6,945,776
Preventive	112,346	$ 5,792,252
Restorative	71,710	$ 6,988,319
Endodontics	7,317	$ 1,830,250
Periodontics	11,922	$ 1,456,026
Prosthodontics	4,624	$ 1,482,972
Oral Surgery	12,633	$ 1,654,949
Orthodontics	6,881	$ 916,388
Adjunctive Services	7,210	$ 547,466
Sub-Total	441,811	$ 27,614,399
Less Adjustments		$ (74,819)
Total		**$ 27,539,580**

FY 2007



FY 2008



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HDS Claims by Service Type - Retirees Plan

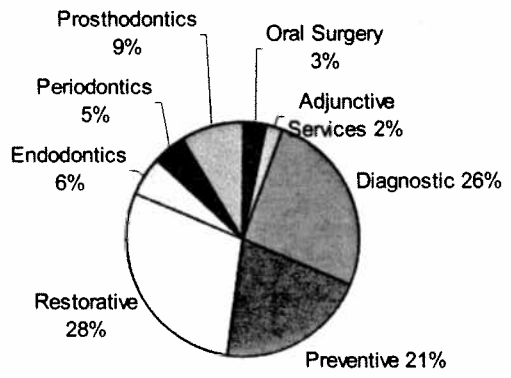
July 1, 2006 through June 30, 2007

Service Type	# of Procedures	Amount Paid
Diagnostic	115,152	$ 3,713,111
Preventive	52,074	$ 3,031,763
Restorative	41,989	$ 4,203,734
Endodontics	3,937	$ 801,597
Periodontics	7,508	$ 657,161
Prosthodontics	6,580	$ 1,281,606
Oral Surgery	5,954	$ 434,723
Adjunctive Services	5,539	$ 309,557
Sub-Total	238,733	$ 14,433,252
Less Adjustments		$ (44,350)
Total		**$ 14,388,902**

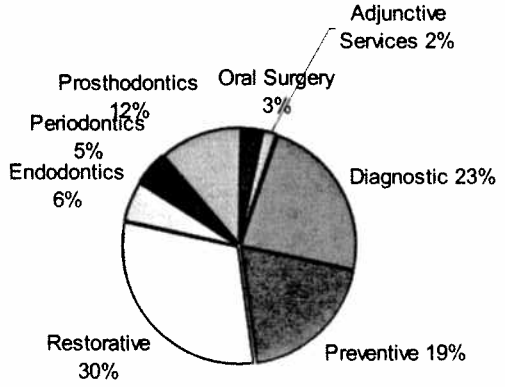
July 1, 2007 through June 30, 2008

Service Type	# of Procedures	Amount Paid
Diagnostic	112,175	$ 3,554,755
Preventive	51,724	$ 3,039,690
Restorative	41,958	$ 4,747,610
Endodontics	3,784	$ 864,579
Periodontics	8,267	$ 776,134
Prosthodontics	7,661	$ 1,845,076
Oral Surgery	6,090	$ 465,521
Adjunctive Services	5,259	$ 308,410
Sub-Total	236,918	$ 15,601,775
Less Adjustments		$ (35,198)
Total		**$ 15,566,577**

FY 2007



FY 2008



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SECTION 8: Vision Plans

Table 30 – VSP Vision Care Plan Financial Results

	Actives - Regular	Retirees
Dues Income	$ 5,110,958	$ 2,749,398
Less Claims	$ (4,369,052)	$ (2,569,523)
Less IBNR	$ (11,637)	$ (19,915)
Less Retention	$ (388,609)	$ (208,973)
Total (Deficit)/Surplus	**$ 341,659**	**$ (49,013)**

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VSP Vision Care Plan Financial Results

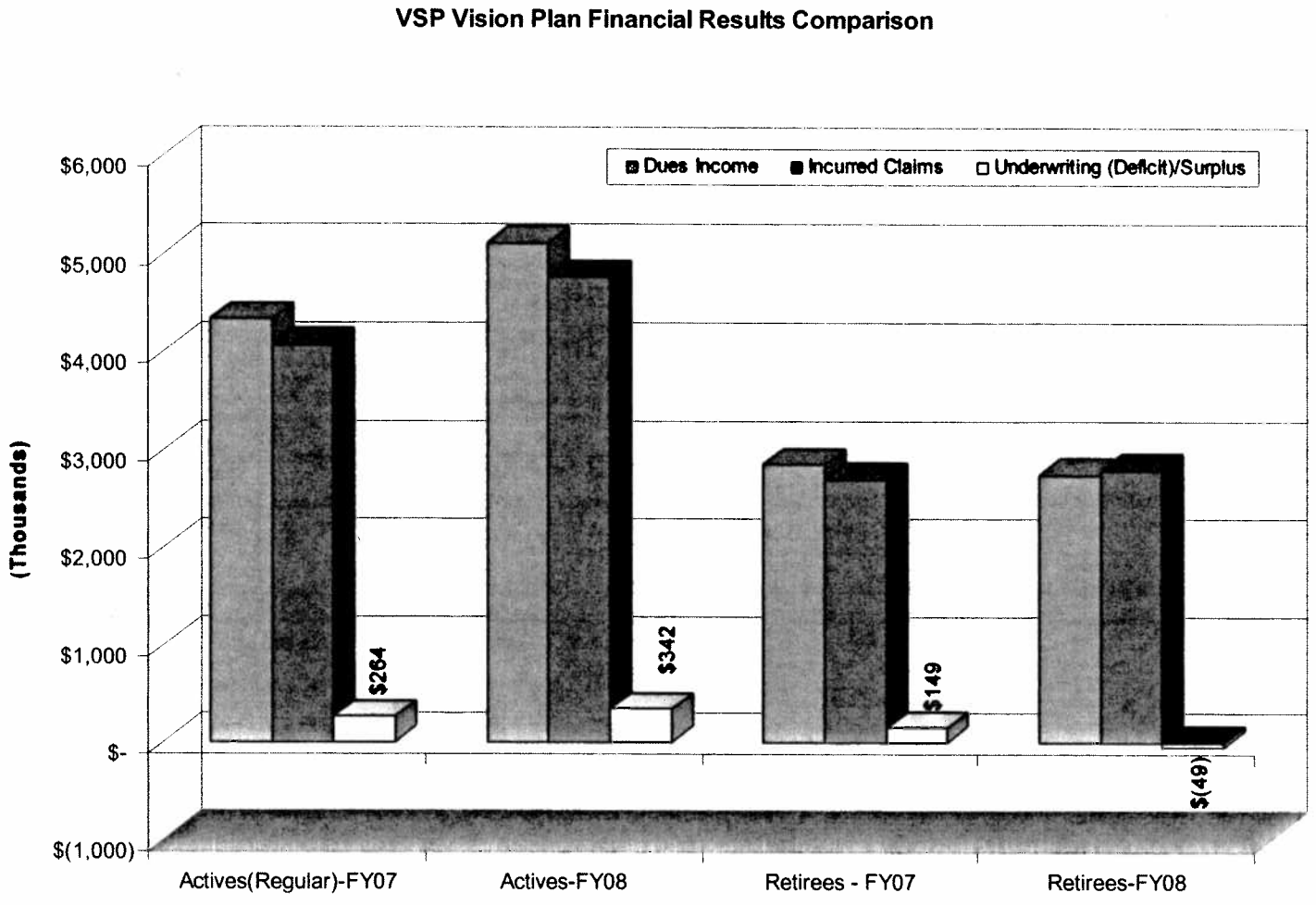

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Table 31 – Vision Plan Enrollment Monthly Average

Actives and Retirees

	Grand Total		Total Actives			Actives - Regular			Actives - Dual			Total Retirees		
Plan Year Ending	Average Enrolled	% change from Prior Year	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total
2004	85,744	N/A	51,929	N/A	60.6%	50,114	N/A	58.4%	1,815	N/A	2.1%	33,815	N/A	39.4%
2005	87,205	1.7%	52,452	1.0%	60.1%	50,743	1.3%	58.2%	1,709	-5.8%	2.0%	34,753	2.8%	39.9%
2006	85,234	-2.3%	49,526	-5.6%	58.1%	48,017	-5.4%	56.3%	1,509	-11.7%	1.8%	35,708	2.7%	41.9%
2007	78,247	-8.2%	42,782	-13.6%	50.2%	42,782	-10.9%	50.2%	0	-100.0%	0.0%	35,465	-0.7%	41.6%
2008	80,022	2.3%	44,012	2.9%	51.6%	44,012	2.9%	51.6%				36,010	1.5%	42.2%

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Vision Plan Enrollment
Monthly Average

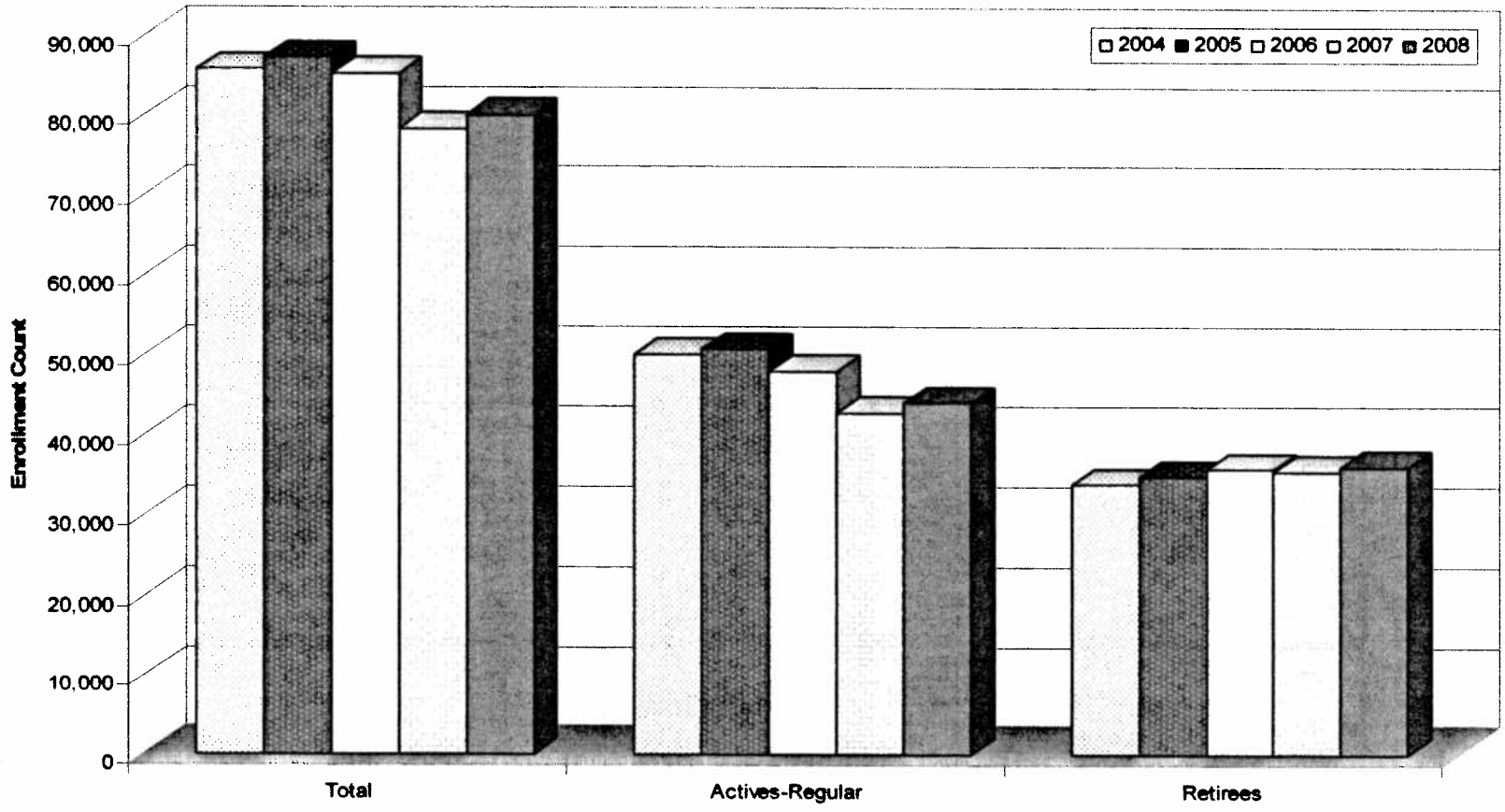

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Table 32 – Monthly Average Vision Plan Enrollment by Tier – 2008 Plan Year

	Average Enrolled	% of Grand Total
Actives		
Single	22,059	
Two Party	8,938	
Family	15,703	
Total	46,699	56.8%
Retirees		
Single	20,537	
Two Party	13,334	
Family	1,706	
Total	35,577	43.2%
Grand Total		
Single	42,596	51.8%
Two Party	22,272	27.1%
Family	17,409	21.2%
Total	82,276	100.0%

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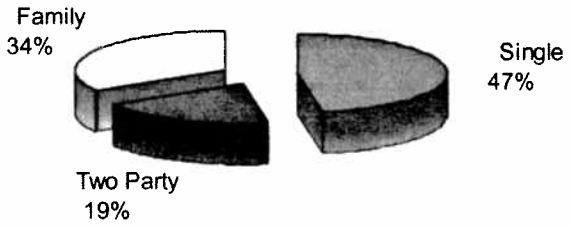
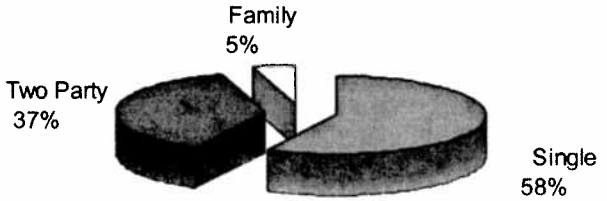
Monthly Average Vision Plan Enrollment by Tier – 2008 Plan Year

Actives



Retirees



Grand Total

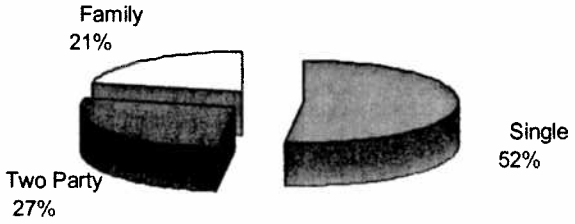


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Table 33 – VSP Financial Results by Bargaining Unit

Actives - Regular Plan	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HSTA	HGEA	UHPA	HGEA
	00	01	02	03	04	05	06	07	08
Dues Income	$ 127,614	$ 876,273	$ 80,100	$ 1,345,406	$ 63,871	$ -	$ 84,788	$ 361,574	$ 234,278
Less Claims	$ (119,928)	$ (539,065)	$ (67,670)	$ (1,248,572)	$ (69,020)	$ 162	$ (89,319)	$ (374,203)	$ (199,130)
Less IBNR	$ (319)	$ (1,436)	$ (180)	$ (3,326)	$ (184)	$ 0	$ (238)	$ (997)	$ (530)
Less Retention	$ (9,699)	$ (66,597)	$ (6,088)	$ (102,251)	$ (4,854)	$ -	$ (6,444)	$ (27,480)	$ (17,805)
Total (Deficit)/Surplus	$ (2,332)	$ 269,175	$ 6,162	$ (8,742)	$ (10,187)	$ 162	$ (11,212)	$ (41,106)	$ 16,812
% of (Deficit)/Surplus	-1.8%	30.7%	7.7%	-0.6%	-16.0%	N/A	-13.2%	-11.4%	7.2%

Actives - Regular Plan	HGEA	UPW	HFFA	SHOPO	HGEA	VASPB	COBRA	Termed Div Run Out	**TOTAL**
	09	10	11	12	13	78			
Dues Income	$ 147,379	$ 312,769	$ 207,512	$ 339,873	$ 882,093	$ 3,288		$ -	$ 5,110,958
Less Claims	$ (116,024)	$ (176,295)	$ (134,047)	$ (264,835)	$ (920,669)	$ (5,226)	$ (45,211)	$ -	$ (4,369,052)
Less IBNR	$ (309)	$ (470)	$ (357)	$ (705)	$ (2,452)	$ (14)	$ (120)	$ -	$ (11,637)
Less Retention	$ (11,201)	$ (23,770)	$ (15,771)	$ (25,830)	$ (67,039)	$ (250)	$ (3,531)	$ -	$ (388,609)
Total (Deficit)/Surplus	$ 19,845	$ 112,234	$ 57,337	$ 48,502	$ (108,068)	$ (2,201)	$ (48,863)	$ 243,790	$ 363,904
% of (Deficit)/Surplus	13.5%	35.9%	27.6%	14.3%	-12.3%				7.1%

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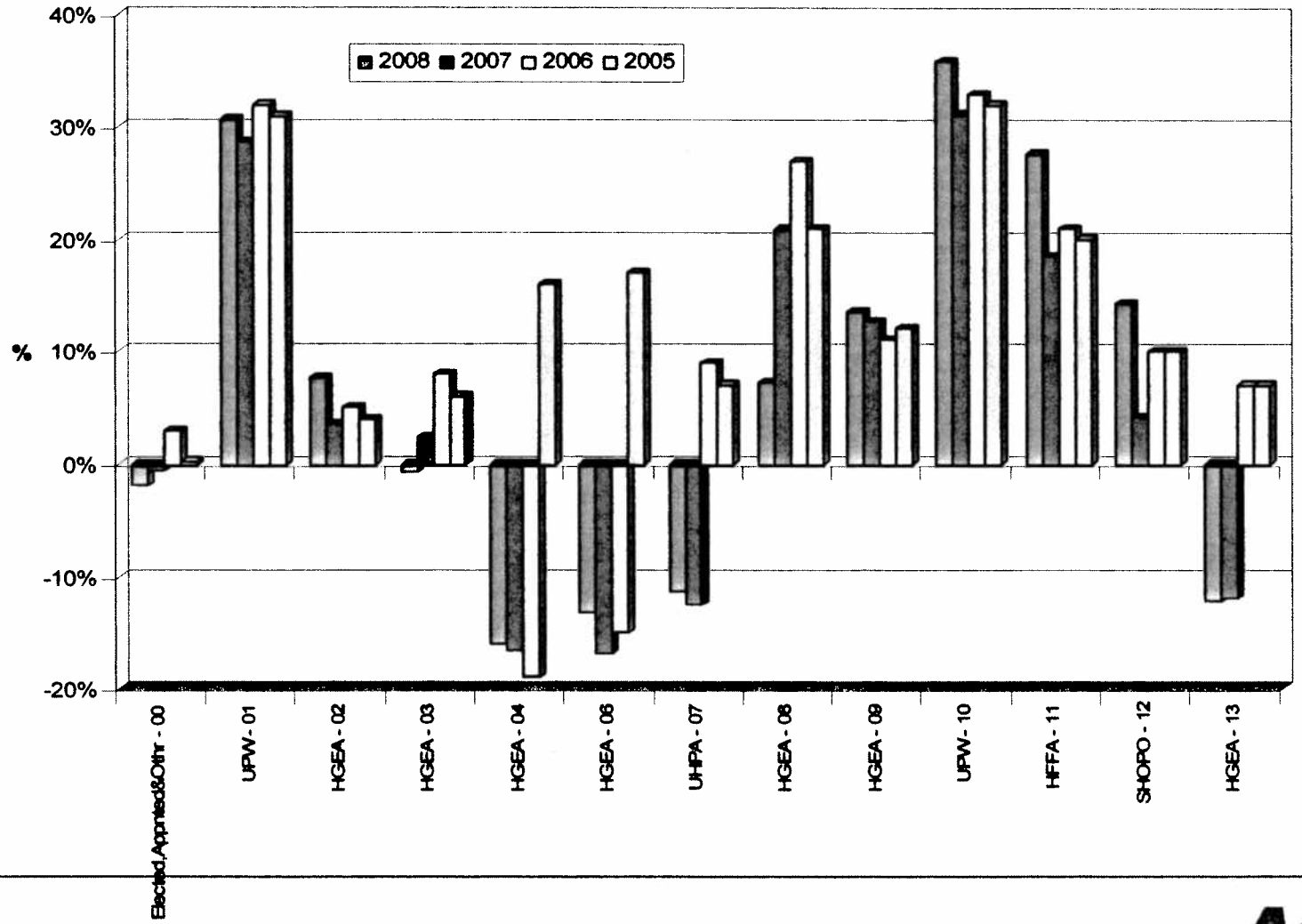
VSP Financial Results by Bargaining Unit - % Deficit/Surplus



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SECTION 9: Life Insurance

Table 34 – Standard Life Insurance Financial Results

	Actives	Retirees	Total
Earned Premium	$2,675,219	$1,574,017	$4,249,236
Paid Claims	$1,736,482	$1,196,730	$2,933,212
Change in Reported Reserves	$92,958	$28,464	$121,422
Change in IBNR Reserves	$202,832	$118,730	$321,562
Total Incurred Claims	$2,032,272	$1,343,924	$3,376,196
Premium Taxes	$73,570	$43,285	$116,855
Administration Fee	$0	$0	$0
Other Expenses and Risk Charges	$393,525	$231,538	$625,063
Total Expenses and Risk Charges	$467,095	$274,823	$741,918
Total (Deficit)/Surplus	**$175,852**	**($44,730)**	**$131,122**

Revised 2/25/09

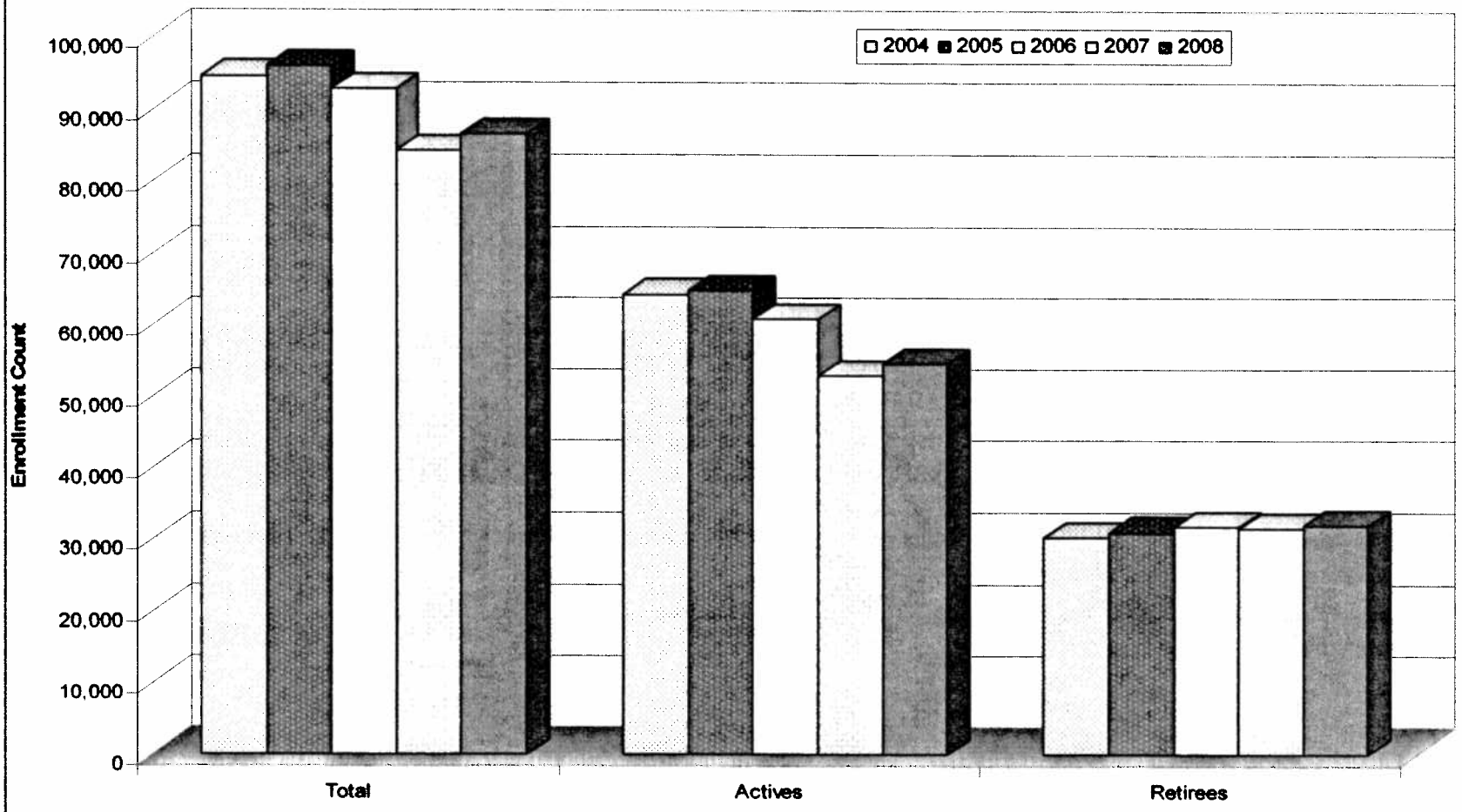
Table 35 – Life Insurance Enrollment Monthly Average

Actives and Retirees

	Grand Total		Total Actives			Total Retirees		
Plan Year Ending*	Average Enrolled	% change from Prior Year	Average Enrolled	% change from Prior Year	% of Grand Total	Average Enrolled	% change from Prior Year	% of Grand Total
2004	94,633	N/A	64,324	N/A	68.0%	30,309	N/A	32.0%
2005	95,951	1.4%	64,889	0.9%	67.6%	31,062	2.5%	32.4%
2006	92,834	-3.2%	60,955	-6.1%	65.7%	31,879	2.6%	34.3%
2007	84,380	-9.1%	52,857	-13.3%	56.9%	31,523	-1.1%	34.0%
2008	86,629	2.7%	54,635	3.4%	58.9%	31,994	1.5%	34.5%

*Standard Life Insurance is the current carrier beginning July 1, 2007. The prior carrier was Aetna Life Insurance.

Life Insurance Enrollment
Monthly Average



Revised 2/25/09

Table 36 – Standard Life Insurance Financial Operations by Bargaining Unit

Actives Plan	Elected, Appointed & Other	UPW	HGEA	HGEA	HGEA	HGEA	UHPA
	00	01	02	03	04	06	07
Earned Premium	$ 75,075	$ 439,328	$ 38,110	$ 769,414	$ 32,750	$ 44,467	$ 192,260
Less Incurred Claims	$ (259,727)	$ (576,399)	$ (39,076)	$ (412,725)	$ (74,871)	$ (3,334)	$ (123,507)
Less Expenses	$ (13,109)	$ (76,707)	$ (6,654)	$ (134,340)	$ (5,719)	$ (7,764)	$ (33,568)
Total (Deficit)/Surplus	$ (197,761)	$ (213,778)	$ (7,620)	$ 222,349	$ (47,840)	$ 33,369	$ 35,185
% of (Deficit)/Surplus	-263.4%	-48.7%	-20.0%	28.9%	-146.1%	75.0%	18.3%

Actives	HGEA	HGEA	UPW	HFFA	SHOPO	HGEA	**TOTAL**
	08	09	10	11	12	13	
Earned Premium	$ 156,675	$ 72,413	$ 147,599	$ 96,107	$ 143,936	$ 467,085	$ 2,675,219
Less Incurred Claims	$ (48,213)	$ (77,956)	$ (47,330)	$ (79,708)	$ (83,277)	$ (242,374)	$ (2,032,272)
Less Expenses	$ (27,356)	$ (12,643)	$ (25,771)	$ (16,780)	$ (25,131)	$ (81,553)	$ (467,095)
Total (Deficit)/Surplus	$ 81,106	$ (18,186)	$ 74,498	$ (381)	$ 35,528	$ 143,158	$ 175,852
% of (Deficit)/Surplus	51.8%	-25.1%	50.5%	-0.4%	24.7%	30.6%	6.6%

Revised 2/25/09

SECTION 10: Performance Guarantees

Table 37 - Performance Guarantee Summary

PERFORMANCE GUARANTEES FOR JULY 1, 2007 THROUGH JUNE 30, 2008

Guarantee	Penalty	HMSA	HMA	Kaiser	HDS	Royal State Supplemental	Royal State Chiro	Standard Life	VSP
Achieve a minimum of 99% financial accuracy	1% of qtrly premium	**99.6%**	**99.0%**	N/A	**99.9%**	**100.0%**	**99.0%**	**100.0%**	N/A
Process 99% of claims within 30 calendar days	1% of qtrly premium	**99.6%**	**99.0%**	N/A	**99.8%**	**100.0%**	**100.0%**	**98.5% ***	N/A
Answer 90% of calls within 30 seconds	1% of annual premium	**93.6%**	**94.0%**	**96.0%**	**91.8%**	**96.8%**	**100.0%**	**93.0%**	N/A
Kaiser: Process 92% of appeals within 60 calendar days	1% of premium	N/A	N/A	**100.0%**	N/A	N/A	N/A	N/A	N/A
Kaiser: Process 96% of claims within 30 calendar days	1% of premium	N/A	N/A	**98.0%**	N/A	N/A	N/A	N/A	N/A
VSP: Maintain call abandonment rate below 3%	1% of premium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**100.0%**
VSP: Maintain an average speed of answer (25 seconds or less)	1% of premium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**12.2 secs**
VSP: Process 99% of claims within 15 business days	1% of premium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**100.0%**

* For 4th Qtr 2007, Standard submitted a penalty check of $10,612.96 for processing 96% of claims w ithin 30 calendar days.

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Appendix I
Utilization Reports

All Actives Combined
MONTHLY MEDICAL/RX PAID CLAIMS REPORT

[redacted]

Plan Year: July 2008 - June 2009

Plan: All Actives Combined

	Enrollment				Fixed Costs	Claims Cost			Total Costs			
Date	**Single**	**2-Party**	**Family**	**Total**	**Total**	**Medical**	**Rx**	**Total**	**Grand Total**	**Budget**	**%**	**PEPM**
Jul-08	19,125	6,048	10,821	35,994	$1,648,908	$16,544,185	$4,249,020	$20,793,204	$22,442,112	$18,299,237	122.6%	$623.50
Aug-08	19,189	6,078	10,846	36,113	$1,654,748	$15,007,337	$4,160,839	$19,168,176	$20,822,924	$18,356,097	113.4%	$576.60
Sep-08	19,294	6,161	10,871	36,326	$1,662,068	$15,020,726	$4,299,746	$19,320,472	$20,982,540	$18,462,779	113.6%	$577.62
Oct-08	19,402	6,218	10,851	36,471	$1,667,613	$15,639,792	$4,404,436	$20,044,227	$21,711,840	$18,516,337	117.3%	$595.32
Nov-08	19,389	6,226	10,869	36,484	$1,668,466	$13,820,591	$4,099,759	$17,920,350	$19,588,817	$18,530,672	105.7%	$536.92
Dec-08	19,472	6,247	10,867	36,586	$1,670,384	$14,338,668	$4,616,111	$18,954,779	$20,625,163	$18,569,120	111.1%	$563.74
Jan-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Feb-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Mar-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Apr-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
May-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Jun-09	-	-	-	-	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
YTD	**115,871**	**36,978**	**65,125**	**217,974**	**$9,972,187**	**$90,371,299**	**$25,829,910**	**$116,201,209**	**$126,173,396**	**$110,734,242**	**113.9%**	
AVG	**9,656**	**3,082**	**5,427**	**18,165**	**$831,016**	**$7,530,942**	**$2,152,492**	**$9,683,434**	**$10,514,450**	**$9,227,854**		
PEPM					**$45.75**	**$414.60**	**$118.50**	**$533.10**	**$578.85**	**$508.02**		

All Actives Combined
MONTHLY MEDICAL/RX PAID CLAIMS REPORT

[redacted]

Plan Year: July 2007 - June 2008

Plan: All Actives Combined

	Enrollment				Fixed Costs	Claims Cost			Total Costs			
Date	**Single**	**2-Party**	**Family**	**Total**	**Total**	**Medical**	**Rx**	**Total**	**Grand Total**	**Budget**	**%**	**PEPM**
Jul-07	17,474	5,051	10,074	32,599	$1,297,897	$4,333,975	$3,125,448	$7,459,423	$8,757,320	$16,147,544	54.2%	$268.64
Aug-07	17,377	5,066	10,038	32,481	$1,297,422	$11,832,366	$3,693,048	$15,525,414	$16,822,836	$16,138,812	104.2%	$517.93
Sep-07	17,403	5,083	10,015	32,501	$1,300,690	$11,539,661	$3,449,371	$14,989,032	$16,289,722	$16,172,870	100.7%	$501.21
Oct-07	17,558	5,133	10,015	32,706	$1,310,384	$13,272,366	$3,835,585	$17,107,951	$18,418,335	$16,285,476	113.1%	$563.15
Nov-07	17,519	5,137	10,006	32,662	$1,310,228	$12,979,465	$3,642,521	$16,621,986	$17,932,215	$16,285,377	110.1%	$549.02
Dec-07	17,494	5,139	10,004	32,637	$1,312,758	$12,794,991	$3,799,892	$16,594,883	$17,907,640	$16,310,313	109.8%	$548.69
Jan-08	17,378	5,106	10,008	32,492	$1,310,252	$14,137,361	$4,035,691	$18,173,052	$19,483,304	$16,263,067	119.8%	$599.63
Feb-08	17,474	5,107	9,997	32,578	$1,314,824	$12,651,684	$3,864,630	$16,516,314	$17,831,137	$16,312,057	109.3%	$547.34
Mar-08	17,537	5,131	10,010	32,678	$1,320,466	$14,268,671	$4,101,053	$18,369,724	$19,690,189	$16,385,692	120.2%	$602.55
Apr-08	17,597	5,179	10,055	32,831	$1,328,874	$13,155,071	$4,140,689	$17,295,760	$18,624,634	$16,489,504	112.9%	$567.29
May-08	17,630	5,222	10,046	32,898	$1,336,981	$16,348,804	$4,155,521	$20,504,326	$21,841,307	$16,620,208	131.4%	$663.91
Jun-08	17,623	5,230	9,999	32,852	$1,332,287	$13,051,851	$4,090,193	$17,142,044	$18,474,331	$16,558,752	111.6%	$562.35
YTD	**210,064**	**61,584**	**120,267**	**391,915**	**$15,773,062**	**$150,366,267**	**$45,933,642**	**$196,299,908**	**$212,072,970**	**$195,969,672**	**108.2%**	
AVG	**17,505**	**5,132**	**10,022**	**32,660**	**$1,314,422**	**$12,530,522**	**$3,827,803**	**$16,358,326**	**$17,672,748**	**$16,330,806**		
PEPM					**$40.25**	**$383.67**	**$117.20**	**$500.87**	**$541.12**	**$500.03**		

All Retirees Combined
MONTHLY MEDICAL/RX PAID CLAIMS REPORT

[redacted]

Plan Year: July 2008 - June 2009

Plan: All Retirees Combined

	Enrollment				Fixed Costs	Claims Cost			Total Costs				
Date	Single	2-Party	Family	Total	Total	Medical	Rx	Total	Grand Total	Subsidy Reimbursement*	Budget	%	PEPM
Jul-08	16,449	11,221	1,483	29,153	$1,471,123	$7,468,267	$7,792,745	$15,261,013	$16,732,135	$1,569,988	$13,856,337	108.5%	$573.94
Aug-08	16,761	11,242	1,468	29,471	$1,477,159	$6,028,005	$7,587,529	$13,615,534	$15,092,693	$1,315,987	$13,926,445	99.0%	$512.12
Sep-08	16,803	11,240	1,463	29,506	$1,478,146	$7,080,645	$7,700,517	$14,781,162	$16,259,308	$1,393,958	$13,920,103	106.2%	$551.05
Oct-08	16,793	11,238	1,453	29,484	$1,477,939	$6,455,318	$8,105,077	$14,560,395	$16,038,333	$1,396,828	$13,894,013	104.9%	$543.97
Nov-08	16,826	11,246	1,430	29,502	$1,477,687	$6,199,412	$7,421,252	$13,620,664	$15,098,351	$1,468,554	$13,865,086	98.5%	$511.77
Dec-08	16,854	11,260	1,430	29,544	$1,479,271	$5,537,591	$8,295,004	$13,832,595	$15,311,866	$1,520,463	$13,869,222	99.5%	$518.27
Jan-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Feb-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Mar-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Apr-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
May-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Jun-09	-	-	-	-	$0	$0	$0	$0	$0	$0	$0	#DIV/0!	#DIV/0!
YTD	**100,486**	**67,447**	**8,727**	**176,660**	**$8,861,326**	**$38,769,238**	**$46,902,124**	**$85,671,362**	**$94,532,688**	**$8,665,778**	**$83,331,207**	**102.8%**	
AVG	**8,374**	**5,621**	**727**	**14,722**	**$738,444**	**$3,230,770**	**$3,908,510**	**$7,139,280**	**$7,877,724**		**$6,944,267**		
PEPM					**$50.16**	**$219.46**	**$265.49**	**$484.95**	**$535.11**	**$49.05**	**$471.70**		

***Low Income Subsidies are evenly distributed among all months**
****Subsidy Reimbursement consists of CMS credit, Low Income Subsidy, and Low Income Premium Subsidy**

All Retirees Combined
MONTHLY MEDICAL/RX PAID CLAIMS REPORT

Plan Year: **July 2007 - June 2008**

Plan: All Retirees Combined

	Enrollment				Fixed Costs	Claims Cost			Total Costs				
Date	**Single**	**2-Party**	**Family**	**Total**	**Total**	**Medical**	**Rx**	**Total**	**Grand Total**	**Subsidy Reimbursement***	**Budget**	**%**	**PEPM**
Jul-07	16,452	11,147	1,476	29,075	$1,268,208	$1,322,200	$5,567,756	$6,889,956	$8,158,164	$20,588	$13,842,939	58.8%	$280.59
Aug-07	16,485	11,197	1,469	29,151	$1,271,826	$4,957,097	$6,936,530	$11,893,627	$13,165,452	$2,987,401	$13,876,666	78.1%	$451.63
Sep-07	16,506	11,226	1,475	29,207	$1,275,005	$4,850,946	$6,136,265	$10,987,211	$12,262,216	$1,496,953	$13,903,121	79.6%	$419.84
Oct-07	16,523	11,271	1,472	29,266	$1,278,716	$6,054,429	$7,136,848	$13,191,277	$14,469,993	$1,425,324	$13,920,334	94.3%	$494.43
Nov-07	16,544	11,229	1,469	29,243	$1,276,532	$6,287,564	$6,953,758	$13,241,322	$14,517,855	$1,548,159	$13,893,185	94.0%	$496.46
Dec-07	16,536	11,223	1,466	29,225	$1,275,306	$5,350,618	$6,940,408	$12,291,026	$13,566,332	$1,498,591	$13,886,989	88.2%	$464.20
Jan-08	16,605	11,303	1,491	29,399	$1,282,624	$6,492,307	$7,574,446	$14,066,754	$15,349,377	$58,203	$14,003,327	109.2%	$522.10
Feb-08	16,636	11,299	1,492	29,427	$1,283,456	$6,697,393	$7,199,724	$13,897,117	$15,180,573	$2,685,147	$14,007,637	90.9%	$515.88
Mar-08	16,659	11,299	1,488	29,446	$1,284,299	$7,629,683	$7,525,067	$15,154,750	$16,439,049	$1,408,670	$14,003,328	106.7%	$558.28
Apr-08	16,661	11,264	1,489	29,414	$1,282,053	$7,018,711	$7,523,605	$14,542,315	$15,824,368	$1,370,672	$13,980,839	103.1%	$537.99
May-08	16,694	11,221	1,491	29,406	$1,280,693	$7,192,556	$7,567,377	$14,759,933	$16,040,627	$1,508,705	$13,960,346	103.7%	$545.49
Jun-08	16,708	11,256	1,489	29,453	$1,283,641	$6,079,588	$7,563,731	$13,643,319	$14,926,960	$1,366,719	$13,975,798	97.3%	$506.81
YTD	**199,009**	**134,935**	**17,768**	**351,712**	**$15,342,359**	**$69,933,091**	**$84,625,515**	**$154,558,606**	**$169,900,965**	**$17,375,134**	**$167,254,511**	**92.0%**	
AVG	**16,584**	**11,245**	**1,481**	**29,309**	**$1,278,530**	**$5,827,758**	**$7,052,126**	**$12,879,884**	**$14,158,414**		**$13,937,876**		
PEPM					**$43.62**	**$198.84**	**$240.61**	**$439.45**	**$483.07**	**$49.40**	**$475.54**		

***Low Income Subsidies are evenly distributed among all months**
****Subsidy Reimbursement consists of CMS credit, Low Income Subsidy, and Low Income Premium Subsidy**

Appendix J
Census Data

TO BE PROVIDED AT A LATER DATE.

Appendix K
Chapter 87A (HRS)

CHAPTER 87A
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

Part I. General Provisions

Part II. Board of Trustees

Part III. Board Powers and Duties

Part IV. Trust Fund

PART I. GENERAL PROVISIONS

§87A-1 Definitions. As used in this chapter:

"Board" means the board of trustees of the Hawaii employer-union health benefits trust fund described in section 87A-5.

"Carrier" means a voluntary association, corporation, partnership, or organization engaged in providing, paying for, arranging for, or reimbursing the cost of, health benefits or long-term care benefits under group insurance contracts.

"Contribution" means money payments made to the fund by the State, the counties, an employee-beneficiary, or a qualified-beneficiary.

"County" means the counties of Hawaii, Honolulu, Kauai, and Maui, including their respective boards of water supply and other quasi-independent boards, commissions, and agencies.

"Dependent-beneficiary" means an employee-beneficiary's:

(1) Spouse;

(2) Unmarried child deemed eligible by the board, including a legally adopted child, stepchild,

foster child, or recognized natural child who lives with the employee-beneficiary; and

(3) Unmarried child regardless of age who is incapable of self-support because of a mental or physical incapacity, which existed prior to the unmarried child's reaching the age of nineteen years.

"Employee" means an employee or officer of the State, county, or legislature,

(1) Including:

(A) An elective officer;

(B) A per diem employee;

(C) An officer or employee under an authorized leave of absence;

(D) An employee of the Hawaii national guard although paid from federal funds;

(E) A retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;

(F) A salaried and full-time member of a board, commission, or agency appointed by the governor or the mayor of a county; and

(G) A person employed by contract for a period not exceeding one year, where the director of human resources development, personnel services, or civil service has certified that the service is essential or needed in the public interest and that, because of circumstances surrounding its fulfillment, personnel to perform the service cannot be obtained through normal civil service recruitment procedures,

(2) But excluding:

(A) A designated beneficiary of a retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;

(B) Except as allowed under paragraph (1)(G), a person employed temporarily on a fee or contract basis; and

(C) A part-time, temporary, and seasonal or casual employee.

"Employee-beneficiary" means:

(1) An employee;

(2) The beneficiary of an employee who is killed in the performance of the employee's duty;
(3) An employee who retired prior to 1961;
(4) The beneficiary of a retired member of the employees' retirement system; a county pension system; or a police, firefighters, or bandsmen pension system of the State or a county, upon the death of the retired member;
(5) The surviving child of a deceased retired employee, if the child is unmarried and under the age of nineteen; or
(6) The surviving spouse of a deceased retired employee, if the surviving spouse does not subsequently remarry;

provided that the employee, the employee's beneficiary, or the beneficiary of the deceased retired employee is deemed eligible by the board to participate in a health benefits plan or long-term care benefits plan under this chapter.

"Fund" means the Hawaii employer-union health benefits trust fund established in section 87A-30.

"Health benefits plan" means:

(1) A group insurance contract or service agreement that may include medical, hospital, surgical, prescribed drugs, vision, and dental services, in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of the services as determined by the board; or
(2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Long-term care benefits plan" means:

(1) A group insurance contract or service agreement in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of long-term care benefits as determined by the board; or
(2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Part-time, temporary, and seasonal or casual employee" means a person employed for fewer than three months and whose employment is less than one-half of a full-time equivalent position.

"Periodic charge" means the periodic payment by the board to a carrier for any health benefits plan or long-term care benefits plan.

"Qualified-beneficiary" means, for purposes of the long-term care benefits plan, a former employee or an

employee who is not eligible for benefits due to a reduction in work hours, including the spouse, divorced spouse, parents, grandparents, in-law parents, and in-law grandparents of an employee or retiree; provided that the beneficiary was enrolled in the plan before the employee or former employee became ineligible for benefits.

"State agency" includes the office of Hawaiian affairs.

"Trustee" means a trustee of the board of trustees of the Hawaii employer-union health benefits trust fund, as described in section 87A-5. [L 2001, c 88, pt of §1; am L 2003, c 152, §1]

PART II. BOARD OF TRUSTEES

§87A-5 Composition of board. *[See explanatory note below.]* The board of trustees of the employer-union health benefits trust fund shall consist of ten trustees appointed by the governor in accordance with the following procedure:

(1) Five trustees, one of whom shall represent retirees, to represent employee-beneficiaries and to be selected as follows:

(A) Three trustees shall be appointed from a list of two nominees per trustee selected by each of the three exclusive representative organizations that have the largest number of employee-beneficiaries;

(B) One trustee shall be appointed from a list of two nominees selected by mutual agreement of the remaining exclusive employee representative organizations; and

(C) One trustee representing retirees shall be appointed from a list of two nominees selected by mutual agreement of all eligible exclusive representatives; and

(2) Five trustees to represent public employers.

Section 26-34 shall not apply to board member selection and terms. Notwithstanding any other provision of this section, no exclusive representative of a bargaining unit that sponsors or participates in a voluntary employee beneficiary association shall be eligible to select nominees or to be represented by a trustee on the board.

As used in this section, the term "exclusive representative" shall have the same meaning as in section 89-2. [L 2001, c 88, pt of §1; am L 2005, c 250, §1]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

§87A-6 Term of a trustee; vacancy. *[See explanatory note below.]* The term of office of each trustee shall be four years; provided that a trustee may be reappointed for one additional consecutive four-year term.

A vacancy on the board shall be filled in the same manner as the trustee who vacated that position was nominated or appointed; provided that the criteria used for nominating or appointing the successor shall be the same criteria used for nominating or appointing the person's predecessor; provided further that vacancies on the board for each trustee position representing retirees and employee-beneficiaries appointed under section 87A-5(1)(A) and (B) shall be filled by appointment of the governor as follows:

(1) If a vacancy occurs in one of the trustee positions described in section 87A-5(1)(A), then the vacancy shall be appointed from a list of two nominees submitted by the exclusive employee representative from among the three largest exclusive employee representatives that does not have a trustee among the three trustee positions;

(2) If a vacancy occurs in a trustee position described in section 87A-5(1)(B), then the vacancy shall be appointed from a list of two nominees submitted by mutual agreement of the exclusive employee representatives described in section 87A-5(1)(B); and

(3) If a vacancy occurs in the retiree position described in section 87A-5(1)(C), then the vacancy shall be appointed from a list of two nominees submitted by mutual agreement of all eligible exclusive employee representatives.

If by the end of a trustee's term the trustee is not reappointed or the trustee's successor is not appointed, the trustee shall serve until the trustee's successor is appointed. [L 2001, c 88, pt of §1; am L 2005, c 250, §2]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

[§87A-7] Chair, vice-chair, and secretary-treasurer. The trustees shall elect from among the members a chair, a vice-chair, and a secretary-treasurer. [L 2001, c 88, pt of §1]

[§87A-8] Compensation and expenses. Each trustee shall serve without compensation, but the trustees may be reimbursed from the fund for any reasonable expenses incurred in carrying out the purposes of the fund. [L 2001, c 88, pt of §1]

[§87A-9] Legal adviser. The attorney general shall serve as legal adviser to the board and shall provide legal representation for the Hawaii employer-union health benefits trust fund. [L 2001, c 88, pt of §1]

[§87A-10] Meetings; notice. Meetings may be scheduled, and notice of meetings shall be provided as follows:

(1) The chairperson may call a meeting of the board at any time by giving at least six calendar days' written notice of the time and place of the meeting to all trustees; and

(2) A majority of the trustees may call a meeting of the board by giving at least ten calendar days' written notice of the time and place to all other trustees. [L 2001, c 88, pt of §1]

[§87A-11] Quorum; board actions; voting. (a) Six trustees, three of whom represent the public employer and three of whom represent employee-beneficiaries, shall constitute a quorum for the transaction of business.

(b) Trustees representing the public employers shall collectively have one vote. Trustees representing the employee-beneficiaries shall collectively have one vote.

For any vote of the trustees representing the public employers to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the public employers shall be deemed to have abstained from voting.

For any vote of the trustees representing the employee-beneficiaries to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the employee-beneficiaries shall be deemed to have abstained from voting.

An abstention shall not be counted as either a vote in favor or against a matter before the board.

(c) Any action taken by the board shall be by the concurrence of at least two votes. In the event of a tie vote on any motion, the motion shall fail. Upon the concurrence of six trustees, the board shall participate in dispute resolution. [L 2001, c 88, pt of §1]

[§87A-11] Quorum; board actions; voting. (a) Six trustees, three of whom represent the public employer and three of whom represent employee-beneficiaries, shall constitute a quorum for the transaction of business.

(b) Trustees representing the public employers shall collectively have one vote. Trustees representing the employee-beneficiaries shall collectively have one vote.

For any vote of the trustees representing the public employers to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the public employers shall be deemed to have abstained from voting.

For any vote of the trustees representing the employee-beneficiaries to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the employee-beneficiaries shall be deemed to have abstained from voting.

An abstention shall not be counted as either a vote in favor or against a matter before the board.

(c) Any action taken by the board shall be by the concurrence of at least two votes. In the event of a tie vote on any motion, the motion shall fail. Upon the concurrence of six trustees, the board shall participate in dispute resolution. [L 2001, c 88, pt of §1]

[§87A-12] Records and minutes. The board shall keep records and minutes of all meetings of the board. [L 2001, c 88, pt of §1]

PART III. BOARD POWERS AND DUTIES

[§87A-15] Administration of the fund. The board shall administer and carry out the purpose of the fund.

Health and other benefit plans shall be provided at a cost affordable to both the public employers and the public employees. [L 2001, c 88, pt of §1]

[§87A-16] Health benefits plan; carriers. (a) The board shall establish the health benefits plan or plans, which shall be exempt from the minimum group requirements of chapter 431.

(b) The board may contract for health benefits plans or provide health benefits through a noninsured schedule of benefits. [L 2001, c 88, pt of §1]

[§87A-17] Group life insurance benefits or group life insurance program. The board may provide benefits under a group life insurance benefits program or group life insurance program to employees. [L 2001, c 88, pt of §1]

§87A-18 Long-term care benefits plan; carrier or third-party administrator. (a) The board may establish a long-term care benefits plan or plans for employee-beneficiaries; the spouses, parents, grandparents, in-law parents, and in-law grandparents of employee-beneficiaries; and qualified-beneficiaries. The plan or plans shall be at no cost to employers and shall comply with article 10H of chapter 431.

(b) Notwithstanding any other law to the contrary, long-term care benefits shall be available only to:

(1) Employee-beneficiaries and their spouses, parents, and grandparents;

(2) Employee-beneficiary in-law parents and grandparents; and

(3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five,

who comply with the plan's age, enrollment, medical underwriting, and contribution requirements.

(c) The board may contract with a carrier to provide fully insured benefits or with a third-party administrator to administer self-insured benefits. [L 2001, c 88, pt of §1; am L 2004, c 216, §14]

[§87A-19] Plans for part-time, temporary, and seasonal or casual employees. (a) The board may offer medical, hospital, or surgical benefits plans to part-time, temporary, and seasonal or casual employees at no cost to the employers. The board may determine eligibility for part-time, temporary, and seasonal or casual employees by rules exempt from chapter 91 as provided in section 87A-26.

(b) The board shall establish the medical, hospital, or surgical benefits plan or plans, which shall be exempt from the minimum group requirements of article 10A of chapter 431. The medical, hospital, or surgical benefits plan or plans shall provide, pay for, arrange for, or reimburse the cost of medical, hospital, or surgical services, and may include prescribed hospital in-patient and out-patient service and medical benefits.

(c) The board may contract for the medical, hospital, or surgical benefits plan or plans. Each part-time, temporary, and seasonal or casual employee enrolled for medical, hospital, or surgical benefits shall pay monthly contributions directly to the board's designated carriers. The monthly contributions may include the carrier's administrative costs. [L 2001, c 88, pt of §1]

§87A-20 REPEALED. L 2004, c 216, §45.

[§87A-21] Eligibility. (a) The board shall establish eligibility criteria to determine who can qualify as an employee-beneficiary, dependent-beneficiary, or qualified-beneficiary, consistent with the provisions of this chapter.

(b) A retired member of the employees' retirement system; a county pension system; or a police, firefighters, and bandsmen pension system of the State or county, shall be eligible to qualify as an employee-beneficiary:

(1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and

(2) Without regard to the date of the retired member's retirement.

(c) A dependent of a retired member shall be eligible to qualify as an employee-beneficiary or dependent-beneficiary:

(1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and

(2) Without regard to the date of the retired member's retirement. [L 2001, c 88, pt of §1]

[§87A-22] Benefits plan information and enrollment. (a) The board shall make information summarizing approved benefits plans available to each employee-beneficiary. The information shall, to the extent reasonably possible, be distributed to each employee-beneficiary at the same time and in the same manner.

(b) The board shall establish conditions and procedures for benefits plan enrollment. [L 2001, c 88, pt of §1]

§87A-23 Health benefits plan supplemental to medicare. The board shall establish a health benefits plan, which takes into account benefits available to an employee-beneficiary and spouse under medicare, subject to the following conditions:

(1) There shall be no duplication of benefits payable under medicare. The plan under this section, which shall be secondary to medicare, when combined with medicare and any other plan to which the health benefits plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall provide benefits that approximate those provided to a similarly situated beneficiary not eligible for medicare;

(2) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a contribution equal to an amount not less than the medicare part B premium, for each of the following who are enrolled in the medicare part B medical insurance plan: (A) an employee-beneficiary who is a retired employee, (B) an employee-beneficiary's spouse while the employee-beneficiary is living, and (C) an employee-beneficiary's spouse, after the death of the employee-beneficiary, if the spouse qualifies as an employee-beneficiary. For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88. If the amount reimbursed by the fund under this section is less than the actual cost of the medicare part B medical insurance plan due to an increase in the medicare part B medical insurance plan rate, the fund shall reimburse each employee-beneficiary and employee-beneficiary's spouse for the cost increase within thirty days of the rate change. Each employee-beneficiary and employee-beneficiary's spouse who becomes entitled to reimbursement from the fund for medicare part B

premiums after July 1, 2006, shall designate a financial institution account into which the fund shall be authorized to deposit reimbursements. This method of payment may be waived by the fund if another method is determined to be more appropriate;

(3) The benefits available under this plan, when combined with benefits available under medicare or any other coverage or plan to which this plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall approximate the benefits that would be provided to a similarly situated employee-beneficiary not eligible for medicare;

(4) All employee-beneficiaries or dependent-beneficiaries who are eligible to enroll in the medicare part B medical insurance plan shall enroll in that plan as a condition of receiving contributions and participating in benefits plans under this chapter. This paragraph shall apply to retired employees, their spouses, and the surviving spouses of deceased retirees and employees killed in the performance of duty; and

(5) The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the medicare part B medical insurance plan, may participate in the plans offered by the fund. [L 2001, c 88, pt of §1; am L 2003, c 111, §1; am L 2006, c 39, §1]

§87A-24 Other powers. In addition to the power to administer the fund, the board may:

(1) Collect, receive, deposit, and withdraw money on behalf of the fund;

(2) Invest moneys in the same manner specified in section 88-119(1)(A), (1)(B), (1)(C), (2), (3), (4), (5), (6), and (7);

(3) Hold, purchase, sell, assign, transfer, or dispose of any securities or other investments of the fund, as well as the proceeds of those investments and any money belonging to the fund;

(4) Appoint, and at pleasure dismiss, an administrator and other fund staff. The administrator and staff shall be exempt from chapter 76 and shall serve under and at the pleasure of the board;

(5) Make payments of periodic charges and pay for reasonable expenses incurred in carrying out the purposes of the fund;
(6) Contract for the performance of financial audits of the fund and claims audits of its insurance carriers;
(7) Retain auditors, actuaries, investment firms and managers, benefit plan consultants, or other professional advisors to carry out the purposes of this chapter;
(8) Establish health benefits plan and long-term care benefits plan rates that include administrative and other expenses necessary to effectuate the purposes of the fund; and
(9) Require any department, agency, or employee of the State or counties to furnish information to the board to carry out the purposes of this chapter. [L 2001, c 88, pt of §1; am L 2004, c 216, §15]

[§87A-25] Other duties. The board shall:
(1) Authorize charges and payments from the fund only upon vouchers countersigned by the chairperson and any other person designated by the board;
(2) Maintain accurate records and accounts of all financial transactions of the fund that shall be audited annually and summarized in an annual report to the governor and legislature;
(3) Maintain suitable and adequate records and provide information requested by State and county employers as necessary to carry out the purpose of the fund;
(4) Procure fiduciary liability insurance and error and omissions coverage for all trustees; and
(5) Procure a fidelity bond of a reasonable amount for the chairperson and any other person authorized to handle fund moneys. [L 2001, c 88, pt of §1]

[§87A-26] Rules; policies, standards, and procedures. (a) The board may adopt rules for the purposes of this chapter. Rules shall be adopted without regard to chapter 91. Rule-making procedures shall be adopted by the board and shall minimally provide for:
(1) Consultation with employers and affected employee organizations with regard to proposed rules;

(2) Adoption of rules at open meetings that permit the attendance of any interested persons;

(3) Approval of rules by the governor; and

(4) Filing of rules with the lieutenant governor.

(b) The board may also issue policies, standards, and procedures consistent with its rules.

(c) The board may adopt rules, without regard to chapter 91, governing dispute resolution procedures in the event of impasse in decision-making; provided that the rules shall be adopted with the concurrence of six trustees.

PART IV. TRUST FUND

§87A-30 Hawaii employer-union health benefits trust fund; establishment. There is established outside the state treasury, a trust fund to be known as the "Hawaii Employer-Union Health Benefits Trust Fund". The fund shall consist of contributions, interest, income, dividends, refunds, rate credits, and other returns. It is hereby declared that any and all sums contributed or paid from any source to the fund created by this part, and all assets of the fund including any and all interest and earnings on the same, are and shall be held in trust by the board for the exclusive use and benefit of the employee-beneficiaries and dependent-beneficiaries and shall not be subject to appropriation for any other purpose whatsoever. The fund shall be under the control of the board and placed under the department of budget and finance for administrative purposes. [L 2001, c 88, pt of §1; am L 2006, c 57, §3]

§87A-31 Trust fund; purpose. (a) The fund shall be used to provide employee-beneficiaries and dependent-beneficiaries with health and other benefit plans, and to pay administrative and other expenses of the fund. All assets of the fund are and shall be dedicated to providing health and other benefits plans to the employee-beneficiaries and dependent-beneficiaries in accordance with the terms of those plans and to pay administrative and other expenses of the fund, and shall be used for no other purposes except for those set forth in this section.

(b) The fund, including any earnings on investments, and rate credits or reimbursements from any carrier or self-insured plan and any earning or interest derived therefrom, may be used to stabilize health and other benefit plan rates; provided that the approval of the governor and the legislature shall be necessary to fund

administrative and other expenses necessary to effectuate these purposes.

(c) The fund may be used to provide group life insurance benefits to employees to the extent that contributions are provided for group life insurance benefits in sections 87A-32 and 87A-37.

(d) The fund may assist the State and the counties to implement and administer cafeteria plans authorized under Title 26 United States Code section 125, the Internal Revenue Code of 1986, as amended, and part II of chapter 78.

(e) At the discretion of the board, some or all of the fund may be used as a reserve against or to pay the fund's future costs of providing health and other benefits plans established under sections 87A-23 and 87A-37 and any other benefits plans the board establishes for retired employees and their beneficiaries. The board may create separate funds within the fund for this purpose. Each separate fund shall be subject to all of the provisions of this chapter. [L 2001, c 88, pt of §1; am L 2006, c 57, §4]

Note

Part II of chapter 78 referred to in text is repealed.

[§87A-31.5] Employer contributions irrevocable. Notwithstanding any law to the contrary, all of the monthly contributions that the State and counties make to the fund under sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, and all other contributions that the State and counties may make to the fund, shall be irrevocable; provided that this shall not preclude the fund from returning contributions or payments made by the State or any county under a mistake of fact within one year after the payment of the contributions or payments. [L 2006, c 57, §2]

[§87A-32] State and county contributions; active employees. (a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreements, whichever is appropriate, for each of their respective employee-beneficiaries and employee-beneficiaries with dependent-beneficiaries, which shall be used toward the payment of costs of a health benefits plan; provided that:

(1) The monthly contribution shall be a specified dollar amount;

(2) The monthly contribution shall not exceed the actual cost of a health benefits plan;

(3) If both husband and wife are employee-beneficiaries, the total contribution by the State or the county shall not exceed the monthly contribution for a family plan; and

(4) If the State or any of the counties establish cafeteria plans in accordance with Title 26, United States Code section 125, the Internal Revenue Code of 1986, as amended, and part II of chapter 78, the monthly contribution for those employee-beneficiaries who participate in a cafeteria plan shall be made through the cafeteria plan, and the payments made by the State or counties shall include their respective contributions to the fund and their employee-beneficiary's share of the cost of the employee-beneficiary's health benefits plan.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreement, whichever is applicable, for each of their respective employees, to be used toward the payment of group life insurance benefits for each employee. [L 2001, c 88, pt of §1]

Note

Part II of chapter 78 referred to in text is repealed.

§87A-33 State and county contributions; retired employees. (a) Notwithstanding any law to the contrary, this section shall apply to state and county contributions to the fund for:

(1) The dependent-beneficiary of an employee who is killed in the performance of duty;

(2) A dependent-beneficiary, upon the death of the employee-beneficiary, except as provided in section 87A-36;

(3) An employee-beneficiary who retired after June 30, 1984, due to a disability falling within sections 88-79 and 88-285;

(4) An employee-beneficiary who retired before July 1, 1984;

(5) An employee-beneficiary who:

(A) Was hired before July 1, 1996;
(B) Retired after June 30, 1984; and
(C) Who has ten years or more of credited service, excluding sick leave;

(6) An employee-beneficiary who:
(A) Was hired after June 30, 1996; and
(B) Retired with twenty-five or more years of credited service, excluding sick leave, except as provided in section 87A-36; and

(7) Employees who retired prior to 1961 and their dependent-beneficiaries.

(b) Effective July 1, 2003, there is established a base monthly contribution for health benefit plans that the State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund, up to the following:

(1) $218 for each employee-beneficiary enrolled in supplemental medicare self plans;
(2) $671 for each employee-beneficiary enrolled in supplemental medicare family plans;
(3) $342 for each employee-beneficiary enrolled in non-medicare self plans; and
(4) $928 for each employee-beneficiary enrolled in non-medicare family plans.

The monthly contribution by the State or county shall not exceed the actual cost of the health benefits plan or plans. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate.

(c) Effective July 1, 2004, there is established a base monthly contribution for health benefit plans that the State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund, up to the following:

(1) $254 for each employee-beneficiary enrolled in supplemental medicare self plans;
(2) $787 for each employee-beneficiary enrolled in supplemental medicare family plans;
(3) $412 for each employee-beneficiary enrolled in non-medicare self plans; and
(4) $1,089 for each employee-beneficiary enrolled in non-medicare family plans.

The monthly contribution by the State or county shall not exceed the actual cost of the health benefit plan or plans and shall not be required to cover increased benefits

above those initially contracted for by the fund for plan year 2004-2005. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate.

(d) The base composite monthly contribution shall be adjusted annually, beginning July 1, 2005. The adjusted base composite monthly contribution for each new plan year (July 1 until June 30) shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years, which percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect at the beginning of the previous plan year.

For the plan year beginning July 1, 2005, the adjusted base monthly contribution shall be computed using the actual contracted premium rate as of July 1, 2004, for medicare and non-medicare, self and family health benefits plans with the highest actual contracted premium rate as of July 1, 2004.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the Secretary of Health and Human Services and approved by the United States Congress.

(e) If the board adopts a rate structure that provides for other than self and family rates for the health benefit plans, the base monthly contribution for the rate structure adopted by the board shall be adjusted to provide the equivalent underwriting cost as the base monthly contribution that is provided for in this section. [L 2001, c 88, pt of §1; am L 2003, c 111, §2; am L 2007, c 26, §1]

[§87A-33.5] State and county contribution; reimbursement for retired employees. Effective July 1, 2007, an employee-beneficiary who retires and relocates outside of the State shall be reimbursed for the premiums paid by the employee-beneficiary for a personal health insurance policy; provided that the board shall determine which employee-beneficiaries and what types of personal health insurance policies shall be eligible for reimbursement and may set other conditions that shall be met for the

employee-beneficiary to receive the reimbursements provided under this section.

The reimbursement shall be the lesser of:

(1) The actual cost of the personal health insurance policy; or

(2) The amount of the state or county contribution for the most comparable health benefits plan.

Reimbursements shall be paid by the fund on a quarterly basis upon the presentation of documentation that the premiums for the personal health insurance policy have been paid by the employee-beneficiary. This section shall apply to all employee-beneficiaries who retire and relocate outside of the State, regardless of their date of retirement. [L 2006, c 167, §1]

[§87A-34] State and county contributions; retired employees with fewer than ten years of service. (a) This section shall apply to state and county contributions to the fund for employees specified in paragraph (1)(E) of the definition of "employee" in section 87A-1 who:

(1) Were hired on or before June 30, 1996; and

(2) Retired after June 30, 1984, with fewer than ten years of credited service, excluding sick leave.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b) for retired employees enrolled in medicare or non-medicare health benefits plans. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1]

§87A-35 State and county contributions; employees hired after June 30, 1996, but before July 1, 2001, and retired with fewer than twenty-five years of service. (a) This section shall apply to state and county contributions to the fund for employees who were hired after June 30, 1996, but before July 1, 2001, and who retire with fewer than twenty-five years of credited service, excluding sick leave; provided that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-33:

(1) An employee hired prior to July 1, 1996, who transfers employment after June 30, 1996, and who

cumulatively accrues at least ten years of credited service; and

(2) An employee hired prior to July 1, 1996, who has at least ten years of credited service prior to a break in service.

For the purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after June 30, 1996, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

(1) For retired employees enrolled in medicare or non-medicare health benefit plans with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b); and

(2) For retired employees enrolled in medicare or non-medicare health benefit plans with at least fifteen but fewer than twenty-five years of service, a monthly contribution of seventy-five per cent of the base monthly contribution set forth under section 87A-33(b).

If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §1]

Note

L 2004, c 184, §3 provides:

"SECTION 3. The board of trustees of the employer-union health benefits trust fund shall establish a process by which public employees affected by this Act shall be notified of the retirement health benefits options provided under this Act."

§87A-36 State and county contributions; employees hired after June 30, 2001, and retired. (a) This section shall apply to state and county contributions to the fund for employees hired after June 30, 2001, and who retired, except that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-35:

(1) An employee hired after June 30, 1996, and prior to July 1, 2001, who transfers employment after June 30, 2001, and who cumulatively accrues at least ten years of credited service; and

(2) An employee hired after June 30, 1996, and prior to July 1, 2001, who has at least ten years of credited service prior to a break in service.

For purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after July 1, 2001, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

(1) For retired employees based on the self plan with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);

(2) For retired employees based on the self plan with at least fifteen but fewer than twenty-five years of service, a monthly contribution equal to seventy-five per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);

(3) For retired employees based on the self plan with twenty-five or more years of service, a monthly contribution equal to one-hundred per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b); and

(4) One-half of the monthly contributions for the employee-beneficiary or employee-beneficiary with dependent-beneficiaries upon the death of the employee, as defined in paragraph (1)(E) of the definition of "employee" in section 87A-1.

If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for two supplemental medicare self or non-medicare self plans, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §2]

Note

L 2004, c 184, §3 provides:

"SECTION 3. The board of trustees of the employer-union health benefits trust fund shall establish a process by which public employees affected by this Act shall be notified of the retirement health benefits options provided under this Act."

[§87A-37] Group life insurance benefits plans for retired employees; contributions. (a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a base monthly contribution as set forth in subsection (b) for each retired employee enrolled in the fund's group life insurance benefits plan under section 87A-34, 87A-35, and 87A-36.

(b) Effective July 1, 2003, there is established a base monthly contribution of $4.16 for each retired employee enrolled in a group life insurance plan; provided that the monthly contribution shall not exceed the actual cost of the group life insurance benefits plan. The base composite monthly contribution shall be adjusted annually beginning July 1, 2004. The adjusted base composite monthly contribution for each new plan year shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years. The percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect through the end of the previous plan year.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to

November 1 of each year after the medicare part B premium rate has been established by the Secretary of Health and Human Services and approved by the United States Congress. [L 2001, c 88, pt of §1]

[§87A-38] State and county contributions not considered wages or salary. Contributions made by the State or the counties under this part shall not be considered wages or salary of an employee-beneficiary. No employee-beneficiary shall have any vested right in or be entitled to receive any part of any contribution made to the fund. [L 2001, c 88, pt of §1]

[§87A-39] Reimbursement for state contributions. (a) All state agencies having control of funds other than the general fund shall reimburse the State for contributions made by the State pursuant to sections 87A-32, 87A-33, 87A-34 87A-35, 87A-36, and 87A-37 on account of agency employees whose compensation is paid in whole or part from funds other than the general fund.

(b) All state and county agencies receiving federal funds, which may be expended for the purpose of replacing the contributions payable by the State to the fund, shall set aside a portion of the federal funds sufficient to reimburse the State for contributions made by the State pursuant to sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, on account of the employees in the agencies whose compensation is paid in whole or part from federal funds. [L 2001, c 88, pt of §1]

[§87A-40] Employee-beneficiary contributions; health benefit plans. (a) Each employee-beneficiary shall make a monthly contribution to the fund amounting to the difference between the monthly charge of the health benefits plan selected by the employee-beneficiary and the contribution made by the State or county for the employee-beneficiary to the fund. Nothing in this section shall prohibit any employee-beneficiary from participating in a cafeteria plan authorized under Title 26 United States Code section 125, Internal Revenue Code of 1986, as amended, and part II of chapter 78.

(b) During the period the health benefits plan selected by an employee-beneficiary is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's

contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution:

(1) In the case of an employee-beneficiary who normally receives the employee-beneficiary's compensation from the comptroller or employees' retirement system, directly to the fund by the first day of each month; or

(2) In the case of all other employee-beneficiaries, to the respective finance officer from whom the employee-beneficiary normally receives compensation for transmittal to the fund by the first day of each month.

(c) Notwithstanding subsection (a), an employee-beneficiary's monthly contribution to the fund shall include the amount that would have been the employee-beneficiary's contribution if the employee-beneficiary had not elected to participate in the cafeteria plan. [L 2001, c 88, pt of §1]

Note

Part II of chapter 78 referred to in text is repealed.

[§87A-41] Employee-beneficiary or qualified-beneficiary contributions; long-term care benefits plan. (a) During the period the long-term care benefits plan is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's monthly contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution directly to the board's designated carrier or third-party administrator as specified by the board.

(b) Qualified-beneficiaries shall pay monthly contributions directly to the board's designated carrier or third-party administrator as specified by the board. [L 2001, c 88, pt of §1]

Appendix L
EUTF Administrative Rules

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

ADMINISTRATIVE RULES

CONTENTS

1.00 GENERAL PROVISIONS

1.01 Purpose

Chapter 87A of the Hawaii Revised Statutes establishes a health trust fund known as the Hawaii Employer-Union Health Benefits Trust Fund. The Fund is to be used to provide eligible state and county employees, retirees, and their dependents with health and other benefit plans at a cost affordable to both the public employers and the public employees. The board is to administer and carry out the purposes of the Fund. These rules are adopted by the board pursuant to Section 87A-26 of the Hawaii Revised Statutes to implement the administration and purposes of the Fund.

1.02 Definitions

As used in these rules, unless otherwise indicated by the context, the following terms shall have the following meanings:

"Administrator" means the administrator of the Fund appointed by the board or the duly authorized representative of the administrator.

"Benefit plan" means a health benefit plan, a group life insurance plan that is subject to Section 79 of the Internal Revenue Code, or any other type of benefit plan except for a long-term care benefit plan.

"Board" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Carrier" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Child" means an employee's, or where applicable, a domestic partner's legally adopted child, a child placed for adoption, stepchild, foster child, or recognized natural child. Except for a recognized natural child of an employee or as otherwise provided by these rules, a child must live with the employee-beneficiary. A child has been placed for adoption when an adoptive parent has assumed custody of and the obligation to support a child in anticipation of adopting the child. A foster child is a child: (1) who lives with an employee in a regular parent-child relationship; and (2) for whom the employee has become the child's guardian or has been awarded legal and physical custody of the child pursuant to a valid court order.

"Contributions" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"County" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Dependent-beneficiary" shall mean the persons described in Rule 3.01 of these rules as being eligible for coverage as dependent-beneficiaries in the health benefit plans offered or sponsored by the Fund.

"Dissolution of domestic partnership" shall occur when: (1) the employee-beneficiary no longer meets the requirements to qualify as a "domestic partner"; (2) one of the partners to the domestic partnership expressly informs the other of the end of their domestic partnership; (3) one of the partners to the domestic partnership takes actions inconsistent with the continued existence of the domestic partnership; or (4) the domestic partnership is otherwise terminated or dissolved.

"Domestic partner" shall mean a person in a spouse-like relationship with an employee-beneficiary who meets the following requirements: (1) the employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely; (2) the employee-

beneficiary and the domestic partner have a common residence and intend to reside together indefinitely; (3) the employee-beneficiary and the domestic partner are and agree to be jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care; (4) neither the employee-beneficiary nor the domestic partner are married or a member of another domestic partnership; (5) the employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii; (6) the employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract; (7) the consent of the employee-beneficiary or the domestic partner to the domestic partnership has not been obtained by force, duress or fraud; and (8) the employee-beneficiary and the domestic partner sign and file with the Fund a declaration of domestic partnership in such form as the board shall from time to time prescribe.

"Employee" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Employee-beneficiary" shall mean the persons described in Rule 3.01 of these rules as being eligible to enroll as employee-beneficiaries in the health benefit plans offered or sponsored by the Fund.

"Employer" or "public employer" shall have the meaning as set forth in Section 89-2 of the Hawaii Revised Statutes.

"Full-time student" means a student who is enrolled in an accredited school, college, or university for not less than the minimum number of credit hours required by such educational institution to have full-time student status.

"Fund" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Fund benefit plan" means a benefit plan offered or sponsored by the Fund.

"Health benefit plan" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Long-term care benefit plan" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Non-Fund benefit plan" means a benefit plan offered or sponsored by a private employer or an entity other than the Fund.

"Part-time, temporary, and seasonal or casual employee" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Periodic change" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Qualified beneficiary" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Qualified medical child support order" means any judgment, decree, or order issued by a court of competent jurisdiction that requires the provision of health benefits coverage to a child of a non-custodial parent.

"Retired member" or "retired employee" means a former employee, officer, appointed or elected official of the State or counties who is currently receiving a retirement or pension allowance from a State or county retirement system or an employee who retired prior to 1961.

"State or county retirement system" means the employees' retirement system, the county pension system, or the police, fire, or bandsmen pension system of the State or any county.

"Trustee" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Trustee group" means the group composed of the five trustees representing public employers or the group composed of the five trustees representing employee-beneficiaries as described in Section 87A-5 of the Hawaii Revised Statutes.

1.03 Public Information

To the extent permitted by applicable federal or state law, the public records of the Fund shall be available for inspection at the Fund's office during regular business hours. All requests for inspection of public records shall be in writing and addressed to the administrator or any other person designated by the board to receive such requests. Copies of public records shall be provided upon the payment of the reasonable costs of reproduction and any fees for searching, reviewing and segregating such records. The board shall establish such costs and fees in accordance with applicable federal and state law.

Protected health information about employee-beneficiaries and dependent-beneficiaries are not public records. Employee-beneficiaries, dependent-beneficiaries, and others may have access to such information only in conformance with the Health Insurance Portability and Accountability Act of 1996 and the rules passed under that Act ("HIPAA"), and the Fund's HIPAA Privacy Policies and Procedures.

1.04 Computation of Time

Whenever a period of time is stated in these rules as a number of days from or after an event: (a) the period shall be computed in calendar days; (b) the day of the event shall not be included in the calculation; and (c) the last day of the period shall be included in the calculation.

1.05 Officers of the Board

(a) The board shall elect a chairperson, vice-chairperson, and secretary-treasurer.

(b) Both the chairperson and vice-chairperson shall be elected from the same trustee group. The secretary-treasurer shall be elected from the other trustee group.

(c) Officer terms shall be for one year beginning July 1, 2002, and shall rotate between the trustee groups annually. The terms of all elected officers shall terminate on June 30 of each succeeding year and such officers shall vacate their offices at that time.

(d) Except as otherwise provided by law or by rules or policies adopted by the board, the duties of the officers shall be as provided in the 10th Edition of *Robert's Rules of Order, Newly Revised.*

(e) The chairperson or vice-chairperson and secretary-treasurer shall coordinate assignments to the administrator and other Fund staff, requests for information, and other matters concerning the administration and operation of the board.

1.06 Committees of the Board

(a) Standing committees shall be established by the board to address critical issues in the major functional areas of the Fund:

(1) The Administrative Committee will have combined administrative and finance committee functions;

(2) The Benefits Committee will have benefits, communication, and appeals committee functions.

(b) The board may establish other committees to address matters related to the operation or administration of the Fund or to investigate issues that impact the Fund.

(c) Committees shall operate informally and shall make recommendations to the full board. Meetings of all standing committees will comply with Part I of Chapter 92 of the Hawaii Revised Statutes.

(d) A minimum of four trustees (two trustees from each trustee group) shall be assigned to a committee. The assigned number of trustees may be larger for certain committees provided that an equal number of trustees are assigned from each trustee group.

(e) Attendance of at least one trustee from each trustee group shall be necessary to convene a committee meeting.

(f) Committees may select a chairperson and any other officers as deemed necessary by the board.

(g) Committee chairpersons shall coordinate assignments to the administrator and other Fund staff for their respective committees.

(h) Trustees in attendance shall agree within their working committees on recommendations made to the full board. When there is no agreement by the trustees in attendance, the committee shall present a summary of the disagreement(s) to the full board.

1.07 Meetings of the Board

(a) To the extent permitted by applicable federal or state law, the meetings of the board shall be open to the public. Without limiting the foregoing, board meetings shall comply with Part I of Chapter 92 of the Hawaii Revised Statutes, including the provisions therein requiring: (1) written and electronic notice of board meetings at least six calendar days prior to each meeting; and (2) written minutes.

(b) The board shall designate the administrator or some other member of the Fund's staff to be responsible for preparing agendas for future board meetings. Any trustee may place a question or subject on the agenda of a future board meeting by notifying the administrator or other designated staff person by 12:00 noon, seven days prior to the board meeting. All board meeting agendas shall be transmitted to the chairperson for review prior to public notice.

(c) Unless otherwise required by the board or applicable law, the parliamentary procedure to be used by the board in the conduct of its meetings shall be in accordance with the 10th Edition of *Roberts Rules of Order, Newly Revised.*

(d) Voting procedures for board meetings and the criteria for a quorum are established in Section 87A-11 of the Hawaii Revised Statutes. In addition, the following voting procedures shall apply:

(1) After a motion is made and seconded, the presiding officer shall read the motion and open the question to discussion and debate by the trustees. When ready to put the motion to a vote, the presiding officer shall call for the public employer and employee-beneficiary trustee votes to determine whether there are three votes from each trustee group in favor of the motion. If so, the motion shall be recorded as having been approved by one vote from the public employer trustees and one vote from the employee-beneficiary trustees.

(2) For routine or procedural matters, the presiding officer may ask if there is any opposition to a motion after it has been made, and to the extent required, seconded and debated. If no opposition is voiced, the motion shall be recorded as having been unanimously approved by one vote by the public employer trustees and one vote from the employee-beneficiary trustees.

(3) If the voting is not unanimous by each side, the names of the trustees who voted in favor of the motion, voted against the motion, or abstained from voting shall be recorded in the minutes.

(4) In the event of a deadlock in a vote of the board on the same question or resolution at two successive meetings of the board, the board shall vote on whether or not to engage in dispute resolution. If six trustees of the board vote to engage in dispute resolution, the two trustee groups shall enter into mediation to attempt to resolve the question or resolution upon which the board has deadlocked.

The mediation shall be handled by a mediator appointed by the Federal Mediation and Conciliation Service. If the Federal Mediation and Conciliation Service fails or refuses to appoint a mediator within ten days of the date on which the six trustees voted to engage in dispute resolution, the mediation shall be handled by a mediator mutually agreeable to the two trustee groups. If the two trustee groups do not agree on a mediator within twenty days of the date on which the six trustees voted to engage in dispute resolution, either trustee group may petition the Administrative Judge of the First Circuit, Circuit Courts of the State of Hawaii, to appoint a mediator. Upon the appointment of a mediator, the two trustee groups shall in good faith enter into mediation on the question or resolution upon which the board has deadlocked. Nothing in this rule is meant to preclude the board from voting to engage in other forms of alternate dispute resolution to resolve a question or resolution upon which it has deadlocked.

(5) Whenever any statute or other law requires a vote of a majority, two-thirds or other percentage or fraction of the trustees or members to which the board is entitled, the motion or other action shall be approved if it receives two votes in favor of the motion or

action as provided in subsection (d)(1), regardless of the total number of votes in favor of the motion or action.

For example, if a statute or other law requires a two-thirds vote of the members to which the board is entitled, the motion or other action will be approved if three trustees from each trustee group vote in favor of the motion or other action, even if the remaining four trustees vote against the motion or other action.

1.08 Appearances Before the Board

(a) All persons shall comply with this rule when appearing before the board. Unless otherwise required by applicable federal or state law, the board shall have the discretion to prescribe additional standards and procedures for all appearances and proceedings before the board. The board may waive or suspend the provisions of this rule with respect to any particular appearance or proceeding before it.

(b) Any person appearing before the board may appear in person, by an officer, partner or regular employee of the party, or be represented by an authorized representative. The board may at any time require any person transacting business with the board in a representative capacity to prove or authenticate the person's authority and qualification to act in such capacity.

(c) The board shall afford all interested persons an opportunity to present oral testimony or submit data, views, or arguments, in writing, on any agenda item.

(1) Persons providing written testimony shall provide thirty copies of their testimony of which twenty copies shall be made available to the public. Twenty copies of materials provided to the board for or during a meeting that are determined to be disclosable shall be made available for distribution to the public.

(2) The board shall hear oral testimony on an agenda item after it has completed discussion of that item. At that time, the presiding officer shall invite members of the public to ask questions or provide comments on the agenda item prior to any action by the board. After the public has had an opportunity to provide input on

the agenda item, the board may discuss the agenda item further and act on the item or move on to the next agenda item.

(3) A person may speak at a board meeting only when recognized to do so by the presiding officer. Comments are limited to three minutes per speaker. Time limitations may be adjusted at the discretion of the presiding officer or at the request of any three trustees. A person may not speak a second time on the same question unless authorized by the presiding officer to do so.

(4) The board may refuse to hear any testimony that is irrelevant, immaterial, or unduly repetitious and may from time to time impose additional conditions as are necessary or desirable for the orderly, efficient, and convenient presentation of oral testimony to the board. The board may request that the person providing oral testimony submit the testimony in writing to the board.

(d) Nothing herein shall require the board to hear or receive any oral testimony or documentary evidence from a person on any matter which is the subject of another proceeding pending before the board.

1.09 Delegation of Authority

To the extent permitted by law, the board may delegate authority to act on its behalf in accordance with board policies and standards to a committee of the board, an administrator, a carrier, a third party administrator, or to such other persons and entities as it deems necessary or reasonable for the effective and efficient administration of the Fund and the provisions of Chapter 87A of the Hawaii Revised Statutes; provided, however, that nothing in this rule shall permit the board to delegate its power to adopt, amend or repeal any rules.

1.10 State Ethics Code

All trustees and employees of the Fund shall comply with Chapter 84 of the Hawaii Revised Statutes.

1.11 Controlling Law

To the extent that federal or state law governs any matter covered by these rules, the Fund and the board shall comply with and follow such federal or state law. To the extent that any matter is not completely governed by federal or state

law, the Fund and the board shall apply these rules to the extent reasonable and practicable.

1.12 Authority of the Board to Waive Rule Provisions

Subject to statutory requirements and limitations, the Board may waive an employee-beneficiary's compliance with any provision of the Fund's rules when the Board determines that: (a) good cause exists for such a waiver; (b) strict enforcement of such provision would impose a manifest injustice upon an employee-beneficiary who has substantially complied with the Fund's rules in good faith; and (c) such waiver does not involve any increase in the obligations or liabilities of the Fund beyond that which would have been involved if the employee-beneficiary had fully complied with the Fund's rules. Each waiver by the Board must be in writing and supported by documentation of the pertinent facts and grounds.

1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

(a) Employee-beneficiaries are responsible for:

(1) Providing current and accurate personal information as per Rules 4.06 and 4.07;

(2) Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;

(3) Paying the employee's premium contributions at the times and in the manner designated by the board; and

(4) Complying with the Fund's rules.

(b) Any public employer whose current or former employees participate in Fund benefit plans is responsible for:

(1) Providing information as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes;

(2) Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit

agreement and at the times and in the manner designated by the board;

(3) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and

(4) Complying with the Fund's rules.

(c) The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

2.00 ADMINISTRATIVE PROCEDURES

2.01 Adoption, Amendment or Repeal of Rules

(a) The board may adopt, amend or repeal any rule of the Fund upon a motion of any trustee or upon the petition of an interested person or organization.

(b) In the case of an interested person or organization, the petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain:

(1) The petitioner's name, address, and telephone number;
(2) A statement of the nature of the petitioner's interest;
(3) A statement of the reasons for the proposed rule, amendment or repeal;
(4) A draft of the proposed rule, amendment or repeal; and
(5) The signature of the petitioner.

The board may reject any petition that does not contain the foregoing information.

(c) The board shall determine whether to deny or proceed with a petition within ninety days. If the petition is denied, the board shall notify the interested person or organization in writing of the denial.

(d) If the board decides to proceed with any proposed rule change, whether by a trustee or interested person or organization, it shall consult with public employers and affected employee organizations with regard to the proposed rule change as follows. First, it shall transmit the proposed rule change to the public employers, exclusive employee organizations, exclusive representatives, retiree organizations, and all other employee organizations registered with the board for consultation prior to adoption. Second, it shall provide the employers, representatives and organizations a

reasonable amount of time for review and comment on the proposed change prior to final action by the board.

(e) After the consultation provided for in subsection (d), the proposed rule change shall be considered for adoption at an open meeting of the board that permits the attendance of interested persons.

(f) All proposed rule changes shall be adopted by the board in accordance with the provisions of section 87A- 26 of the Hawaii Revised Statutes.

(g) New rules, amendments or repeals of rules that are adopted by the board shall be submitted to the governor for approval and filed with the lieutenant governor's office.

(h) Unless some other date is expressly selected by the board, a new rule, amendment of a rule, or repeal of a rule shall be effective the first day after the rule, amendment, or repeal is filed with the lieutenant governor's office.

2.02 Policies, Standards, and Procedures

Policies, standards and procedures to be adopted amended or repealed may, at the discretion of the board, be transmitted to public employers and affected employee organizations for consultation purposes. Nothing herein shall require the board to consult with public employers or affected employee organizations concerning the board's adoption, amendment or repeal of policies, standards and procedures or to transmit any such policies, standards or procedures to public employers or affected employee organizations for consultation purposes.

2.03 Declaratory Rulings

(a) Any interested person may petition the board for a declaratory ruling as to the applicability of any statutory provision administered by the board or of any rule or order of the Fund.

(b) Every petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain the following:

(1) The petitioner's name, address, and telephone number;
(2) A designation of the specific statute, rule or order in question;

(3) A statement of the nature of the petitioner's interest, including the reasons for the submittal of the petition;
(4) A complete statement of the relevant and material facts;
(5) A statement of the position or contentions of the petitioner; and
(6) A full discussion of the reasons, including any legal authorities, in support of the petitioner's position or contention.

The board may reject any petition that does not contain the foregoing information.

(c) Petitions to intervene and become a party to a declaratory ruling proceeding may be submitted in writing to the board. Such petitions shall contain the same information as required under subsection (b) and the grounds and reasons on which intervention is sought. The Board may deny intervention where the petition to intervene raises issues not reasonably pertinent to the issues already presented or the petition raises issues that would broaden the issues to be decided. If intervention is granted, the petitioner shall become a party to the proceeding to the degree permitted by the order granting intervention.

(d) The board may dismiss any petition for a declaratory ruling for good cause. Without limiting the generality of good cause, the board may dismiss a petition if:

(1) The question raised is purely speculative or hypothetical;
(2) The petitioner's interest is not of the type or nature that would give the petitioner standing to maintain an action if the petitioner were to seek judicial relief;
(3) The issuance of a declaratory ruling may adversely affect the interests of the employer, the board, any of the trustees, the Fund, or any of the Fund's officers or employees in litigation which is pending or reasonably expected to arise in the future; or
(4) The matter is not within the jurisdiction of the board.

(e) Subject to applicable federal and state law, the board at its discretion shall:

(1) Render a decision on the petition for a declaratory ruling without a hearing; or
(2) Hold a hearing and thereafter render its decision on the petition; or
(3) Refer the petition for consideration or hearing to the administrator, a special or standing committee of the board or any other person or

entity duly designated by the board. After considering the recommendation of the administrator, committee or designated person or entity, the board shall render its decision on the petition.

Where any question of law is involved, the board may seek the assistance of the state attorney general in reviewing the matter. The board may also seek the assistance of other government agencies when necessary or desirable.

Any petitioner who desires a hearing shall submit a written request for a hearing together with the petition for a declaratory ruling. The written request shall set forth in detail the reasons why the matters alleged in the petition, together with supporting affidavits or other written evidence and briefs or memoranda of legal authorities, will not permit the fair and expeditious disposition of the petition and, to the extent that the request for a hearing is dependent upon factual assertions, shall submit affidavits or certificates establishing those facts.

(f) The petition for a declaratory ruling shall either be rejected in accordance with subsection (d) or acted upon by issuance of an order within ninety days. Upon the disposition of the petition, the board shall promptly notify the petitioner.

(g) Orders disposing of petitions for a declaratory ruling will have the same status as other agency orders. An order shall be applicable only to the fact situation alleged in the petition or as set forth in the order. An order shall not be applicable to different fact situations or where additional facts exist that were not considered in the order.

2.04 Administrative Appeals

(a) A person aggrieved by one of the following decisions by the Fund may appeal to the board for relief from that decision:

(1) A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the Fund;

(2) A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;

(3) A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund; or

(4) A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund.

(b) The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

(1) The aggrieved person's name, address, and telephone number;
(2) A description of the decision with respect to which relief is requested, including the date of the decision;
(3) A statement of the relevant and material facts; and
(4) A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

(c) If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office. The written appeal need not be in any particular form but shall contain the following information:

(1) The aggrieved person's name, address and telephone number;
(2) A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;

(3) A description of the decision with respect to which relief is requested, including, the date of the decision;

(4) A complete statement of the relevant and material facts;
(5) A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
(6) A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

(d) The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

(e) The board shall grant or deny the appeal within a reasonable amount of time. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

(f) At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

2.05 Emergency Appeals

(a) An employee-beneficiary ("appellant") who is aggrieved by a plan administrator's decision denying or limiting benefits provided under a plan offered by the Fund to the employee-beneficiary or a dependent-beneficiary enrolled by the employee beneficiary may make an emergency

appeal directly to the Board where a delay in following the Fund's normal appeal process could:

(1) Seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary;
(2) Seriously jeopardize the employee-beneficiary's or dependent-beneficiary's ability to regain maximum functioning; or
(3) In the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary, subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

(b) Any appellant desiring to make an emergency appeal under this Rule shall file a written request with the Fund administrator that contains the following information:

(1) The name, address, and telephone number of the appellant;
(2) A description of the decision with respect to which relief is requested;
(3) A statement of the relevant and material facts;
(4) A statement as to why the appellant is appealing the decision, including all arguments and reasons that support the appellant's position or contentions;
(5) A statement as to why the appellant's appeal qualifies as an emergency appeal, i.e., why the appeal meets one or more of the conditions stated in subsection (a) above;
(6) A statement as to exactly what relief the appellant is seeking;
(7) Any documents and records that support the appellant's appeal, including, but not limited to, any opinions from physicians that show that the appeal should be handled as an emergency appeal; and
(8) If the appellant is going to be represented by a third person on the appeal: (i) a signed authorization by the appellant designating the third person to represent him or her on the appeal; or (ii) other documentation establishing the right of the third person to represent the appellant. Such documentation may include letters of guardianship, a power of attorney, or any other document establishing that the third person may represent the appellant. Appropriate representatives may include, but are not limited to, the parent, child, spouse or domestic partner of the appellant.

Notwithstanding the foregoing, the Fund administrator may waive the foregoing requirements if the Fund administrator finds that the criteria for making an emergency appeal are present and circumstances prevent the appellant from filing a written request for an appeal.

(c) Within two business days of receipt of a request for emergency appeal, the Fund administrator shall determine whether the request for emergency appeal qualifies as an emergency appeal under the criteria stated in this Rule. If the Fund administrator determines that the request for emergency appeal does not qualify as an emergency appeal, the appellant's appeal shall be handled as a normal appeal. Appellant may appeal the Fund administrator's denial of a request for emergency appeal by filing a written request with the Fund Administrator. No particular form is required for such a written request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.

(d) Upon determining that an appeal qualifies as an emergency appeal or upon receipt of an appeal of the Fund administrator's denial of a request for emergency appeal, the Fund administrator shall take the following actions:

(1) Set a time and date of a hearing when a quorum of the Board can be present. Subject to quorum requirements, the hearing shall be set within five business days of: (i) the date of the Fund administrator's determination that the appeal qualifies as an emergency appeal, or (ii) the date of receipt of an appeal of the Fund administrator's denial of a request for emergency appeal;

(2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;

(3) Notify the plan administrator of the time and date of the hearing, provide the plan administrator with a copy of the written request for an emergency appeal filed by the appellant, and invite the plan administrator to submit a written statement of the plan administrator's position regarding the emergency appeal. If the plan administrator submits such a written statement, a copy shall be provided by the Fund administrator to the appellant;

(4) In the notices to the appellant and plan administrator, the Fund administrator shall request the parties to provide the Fund administrator with copies of any documents, records, written

testimony, or other written evidence that they wish the Board to consider at the hearing. To facilitate the hearing, the Fund administrator may request that the parties stipulate to the admission of all or any of such documents, records, written testimony, or other written evidence; and

(5) Prior to the hearing, the Fund administrator shall provide each member of the Board that will attend the hearing with copies of the written request for an emergency appeal and any written statement of position by the plan administrator.

(e) Unless the appellant expressly requests a public hearing, any hearing under this Rule shall be closed to the public. At the hearing, the following procedures shall apply:

(1) The hearing shall be chaired by the EUTF chair, vice-chair, or secretary-treasurer. If none of these officers is present, the Board shall elect one of their members to chair the hearing;

(2) The chair shall be in charge of regulating the course and conduct of the hearing;

(3) The chair shall make all rulings on the admission, exclusion, or limitation of testimony and evidence. The admissibility of testimony and evidence shall not be governed by the laws of evidence. All relevant oral or documentary evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. Irrelevant, immaterial, or unduly repetitious material shall not be admitted into evidence. The chair shall give effect to the privileges recognized by law;

(4) At the outset of the hearing, the chair shall provide a brief overview of the procedures that will apply to the hearing. Following this, the Fund administrator or other representative of the Fund staff shall state the nature and background of the proceeding, including the name of the appellant, the decision being appealed, and the relief being requested;

(5) After the presentation by the Fund administrator or staff, the appellant shall present his or her testimony, evidence, and arguments in support of the appeal. Following the appellant, the plan administrator shall present its testimony, evidence, and argument, if any, in support of the decision being appealed. At any time during the hearing, the Board may ask questions to the appellant, plan administrator, Fund staff, and any witnesses who

testify at the hearing. At the conclusion of the hearing, both the appellant and plan administrator may present final arguments in support of their positions;

(6) At any time during the hearing, the Board may enter executive session to consult counsel regarding any legal issues involved in the appeal; and

(7) Prior to the conclusion of the hearing, the Board shall announce its decision on the appeal to the appellant and plan administrator. The Board shall subsequently issue the Board's decision in writing. A certified copy of the written decision shall be sent by certified mail, return receipt requested, to the appellant and plan administrator within a reasonable time after the hearing.

(f) The Fund administrator may designate one or more EUTF staff members to perform any or all of the Fund administrator's duties under this Rule when the Fund administrator is unavailable or otherwise unable to perform such duties.

3.00 ELIGIBLITY FOR ENROLLMENT

3.01 Health Benefits

(a) Employee-beneficiaries. The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the Fund:

(1) An employee;
(2) A retired employee;
(3) The surviving spouse or domestic partner of an employee who is killed in the performance of the employee's duty, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership;
(4) The unmarried child of an employee who is killed in the performance of the employee's duty, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary;
(5) The surviving spouse or domestic partner of a deceased retired employee, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership; and
(6) The unmarried child of a deceased retired employee, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsections (3) and (5), a surviving spouse or domestic partner ceases to be an eligible employee-beneficiary once the spouse or domestic partner remarries or enters into a domestic partnership even though the spouse or domestic partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of domestic partnership, or death. A surviving domestic partner shall not cease to be eligible under subsections (3) or (5) because the death of the employee or retired employee prevents him or her from further meeting the requirements of parts (1), (2), (3), (6), and (8) of the definition of "domestic partner" in Rule 1.02. With respect to subsections (4) and (6),

an unmarried child ceases to be eligible as of midnight of the child's nineteenth birthday.

Notwithstanding any other provision in these rules to the contrary, an employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any benefit plan offered or sponsored by the Fund until the employee-beneficiary enrolls in the Medicare Part B medical insurance plan.

(b) Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:

(1) An employee-beneficiary's spouse or domestic partner;
(2) An employee-beneficiary's or domestic partner's unmarried child, provided the child is either under the age of nineteen or a full-time student and under the age of twenty-four;
(3) An employee-beneficiary's or domestic partner's unmarried child, regardless of age, who is incapable of self-support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen; and
(4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order.

With respect to subsection (2), an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday, as applicable. With respect to subsections (2) and (3), the child of a domestic partner ceases to be eligible upon the dissolution of the domestic partnership. In addition, as a condition of eligibility for any child over the age of nineteen, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

Notwithstanding any other provisions in these rules to the contrary, a dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary has enrolled in the Medicare Part B medical insurance plan.

3.02 Long-Term Care

The following persons shall be eligible for any long-term care benefit plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, medical underwriting and contribution requirements of such plans:

(1) Employee-beneficiaries and their spouses, parents, and grandparents;
(2) Employee-beneficiaries' in-law parents and grandparents; and
(3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five.

3.03 Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

4.00 ENROLLMENT PROCEDURES

4.01 Application for Enrollment

(a) An employee-beneficiary shall file an enrollment application, in the form prescribed by the board or by the board's policy, to enroll, change or cancel an enrollment in any benefit plan, including long term care, offered or sponsored by the Fund. Unless otherwise provided by the board or by the board's policy, all enrollment applications shall be filed by the employee-beneficiary with: (1) in the case of an employee, the employee's employer; and (2) in all other cases, the Fund. Notwithstanding the foregoing, upon retirement, an employee-beneficiary shall file an enrollment application to enroll or change enrollment in the benefit plans offered or sponsored by the Fund with the entity that pays his or her retirement or pension allowance. Thereafter, the retired employee-beneficiary shall file any and all enrollment applications directly with the Fund.

(b) With due consideration of appropriate federal or state laws, the board shall set the standards and procedures for filing such enrollment applications, including, but not limited to, the form of such enrollment applications, the information required to be provided by the employee-beneficiary on such enrollment applications, and the method for filing such enrollment

applications. Enrollment applications shall include the employee-beneficiary's authorization to the state comptroller or the appropriate county director of finance to assign sufficient compensation to the Fund in payment of all contributions due from such employee-beneficiary for enrollment or coverage in any and all Fund benefit plans.

(c) A representative of an employee-beneficiary may file an enrollment application for the employee-beneficiary if:

(1) The representative has a written authorization signed by the employee-beneficiary that authorizes the representative to file such enrollment applications; or
(2) A valid court order authorizes the representative to file such enrollment applications.

4.02 Rejection of an Enrollment Application

(a) Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

(b) An enrollment application shall be rejected if:

(1) The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
(2) The application is not filed within the time limitations prescribed by these rules;
(3) The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
(4) The employee-beneficiary owes past due contributions or other amounts to the Fund; or
(5) Acceptance of the application would violate applicable federal or state law or any other provision of these rules.

(c) Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

4.03 Dual or Multiple Enrollment

(a) No person may be enrolled simultaneously in any benefit plan offered or sponsored by the Fund as both an employee-beneficiary and a dependent-beneficiary, nor may unmarried children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.

(b) Where an employee-beneficiary files more than one enrollment application, the enrollment application bearing the latest filing date shall be the one used by the Fund to process the employee-beneficiary's enrollment, provided the employee-beneficiary is eligible for such enrollment.

4.04 Date of Filing

An employee-beneficiary's enrollment application, beneficiary designation, or any other form required to be filed with the Fund shall be deemed to have been filed with the Fund on the date that the following entities, as applicable, actually receive such forms: (1) the employee-beneficiary's employer; (2) the entity that pays the employee-beneficiary's retirement or pension allowance; or (3) the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, beneficiary designation, or other form shall be deemed to have been filed on the date that the person would have been first eligible to file that document.

4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates

Except as otherwise provided in these rules or by applicable federal or state law, the following shall apply to all applications to enroll in the benefit plans offered or sponsored by the Fund, to add or delete dependent-beneficiaries, or to change enrollments or coverages:

(a) No enrollment of an employee-beneficiary, addition or deletion of a dependent-beneficiary, or change in an enrollment or coverage shall be effective without the filing of a properly completed enrollment application.

(b) The effective dates of coverage, deletions of coverage, and changes in coverage shall be dependent on the filing of a properly completed

enrollment application within thirty days of the specified event that allows the filing of the application.

(c) An employee-beneficiary who fails to file an enrollment application within the time prescribed by subsection (b) or any otherwise applicable rule shall not be permitted to file that application until the next open or special enrollment period.

4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund in writing of any changes in the employee-beneficiary's name or address or marital or domestic partnership status, of the birth or adoption of a child or any other changes in the family status of the employee-beneficiary, and any other material changes in the information previously filed by the employee-beneficiary as part of an enrollment application. Each notice to the Fund shall be submitted through the employee-beneficiary's employer or, if none, shall be submitted directly to the Fund.

4.07 Verification of Eligibility

The board may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in Fund benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.12(d).

4.08 Exceptions to the Timely Filing of an Enrollment Application

(a) Rule 4.05 and the times for filing enrollment applications prescribed in these rules shall not apply to the following persons:

(1) Retired members who are currently enrolled in a benefit plan offered or sponsored by the Fund;

(2) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of a deceased retired member who is eligible as an employee-beneficiary under Rule 3.01(a); and

(3) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of any employee who is killed in the performance of duty who is eligible as an employee-beneficiary under Rule 3.01(a).

(b) Coverage for the persons covered by subsection (a) shall become effective on the later of:

(1) The date of the event that makes the person eligible for enrollment when a properly completed enrollment application is filed within thirty days of the event; or

(2) The first day of the month following the date the person files a properly completed enrollment application.

(c) Nothing in this rule shall permit an employee-beneficiary or dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan to be covered under any benefit plan offered or sponsored by the Fund until enrolled in the Medicare Part B medical insurance plan. Further, nothing in this rule is meant to permit the enrollment of any person who is not otherwise eligible for enrollment in the benefit plan offered or sponsored by the Fund.

4.09 Open and Special Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during an open or special enrollment period to make any one or a combination of specific enrollment changes that have been approved by the board for that open or special enrollment period. The changes that the board may approve include, but are not limited to, changes from non-enrolled to enrolled status, changes between plans, changes in levels of coverage, and cancellations. All changes made shall become effective on the date approved by the board for the open or special enrollment period.

4.10 Continuation of Coverage

Subject to applicable federal and state law, coverage under the benefit plans offered or sponsored by the Fund shall continue:

(a) Provided the employee-beneficiary meets the eligibility provisions of Rule 3.01 and pays the employee's premium contribution as provided by

statute, the employer's administrative rules, or an applicable bargaining unit agreement;

(b) While the employee-beneficiary participates in an employee strike authorized by chapter 89, Hawaii Revised Statutes, provided that nothing in this rule shall limit the right or ability of the Fund to collect premium contributions from any public employer or employee-beneficiaries or the remedies available to the Fund to collect such premium contributions.

(c) When an employee terminates employment and is rehired by a public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment. The employee shall be treated as if continuously enrolled in the Fund benefit plans in which the employee was enrolled at the time of termination and shall be required to pay the full cost of coverage to the extent that such is not paid by the employee's public employer. The employee shall not be allowed to change between plans unless the employee's current Fund benefit plan is unavailable at the employee's new employment location.

4.11 Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within thirty days of the date on which the required semi-monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.12(c), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.14(b).

4.12 Cancellation of Enrollment; Effective Dates of Cancellation

(a) Voluntary Cancellation Requested by the Employee-Beneficiary. An employee-beneficiary may voluntarily cancel enrollment in a Fund benefit plan at any time by filing an enrollment application requesting cancellation with the employee-beneficiary's employer or, if none, directly with the Fund. The effective date of cancellation shall be the first day of the pay period following the requested cancellation date or, if no date is specified, the effective date of cancellation shall be the first day of the pay

period after which the Fund receives the employee-beneficiary's request for cancellation.

(b) Cancellation Due to Ineligibility. The enrollment of any ineligible person who was enrolled in error or is ineligible to enroll in or be covered in a benefit plan offered or sponsored by the Fund shall be canceled:

(1) When the person is notified of the error or ineligibility prior to the effective date of the enrollment, the person shall be treated as if the enrollment application was not submitted.

(2) When the person is notified after the effective date of the enrollment, the enrollment shall be canceled on the first day of the second pay period that follows the date of the Fund's notice of cancellation to the ineligible person or employee-beneficiary.

(c) Cancellation Due to Failure to Pay Contribution Shortage. If any portion of an employee-beneficiary's required semi-monthly or monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund within 30 days of the date of the notice of contribution shortage, the employee-beneficiary's enrollment and all coverages for dependent-beneficiaries under that enrollment shall be cancelled as of the first day following the last period for which full payment of the employee-beneficiary's required semi-monthly or monthly contributions were paid and transmitted to the Fund. However, the enrollment of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.14(b). Cancellation of an employee-beneficiary's enrollment pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.

(d) Cancellation Due to Failure to Comply with Rules. If an employee-beneficiary materially fails to comply with any of the Fund's rules, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be canceled after notice of such has been provided to the employee-beneficiary. The board may set standards and procedures for providing notice to employee-beneficiaries under this rule. The notice shall at a minimum specify how the employee-beneficiary has failed to comply with the Fund's rules, and a date by which the employee-beneficiary must comply with the Fund's rules in order to avoid

cancellation. The effective date of the cancellation shall be the date set forth in the notice as to when the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation.

4.13 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Change in Employment Status. An employee-beneficiary's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the employee-beneficiary's loss of eligibility to participate in such plans due to a change in employment status. The effective date of the termination shall be the first day of the pay period following the effective date of the change in employment status.

(b) Termination Due to Filing of Fraudulent Claims. An employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be terminated if the employee-beneficiary files fraudulent claims for benefit. A dependent-beneficiary's coverage in all of the benefit plans offered or sponsored by the Fund may be terminated if the dependent-beneficiary files fraudulent claims for coverage and/or benefits. The effective date of the termination shall be the date that the Fund determines that the employee-beneficiary or dependent-beneficiary, as applicable, has filed fraudulent claims.

(c) Notice to the Fund; Recovery of Benefits. If an event occurs that makes a person ineligible for continued enrollment or coverage in the benefit plans offered or sponsored by the Fund, that person or employee-beneficiary shall notify the Fund of the event as soon as reasonably practicable. All such notices shall be in writing and shall be sent to the Fund. The Fund shall be entitled to seek recovery of any benefits that were provided to any person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment in or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule, the Fund shall have the rights of offset and set-off, including without limitation, the right to recover amounts from and out of any and all future benefits payable to the person whose enrollment was terminated or who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans.

4.14 Reinstatement of Enrollment

(a) General Rule. Unless another rule of the Fund expressly applies, an employee-beneficiary whose enrollment in any of the Fund's benefit plans has been cancelled or terminated may not apply for reinstatement in those benefit plans. The employee-beneficiary may only apply for a new enrollment during the Fund's next open enrollment period. Any such new enrollment may be conditioned upon the employee-beneficiary meeting all the Fund's rules for eligibility and enrollment, curing any past deficiencies or failures that led to the employee-beneficiary's cancellation or termination, and providing adequate assurance that the employee-beneficiary will not further engage in the conduct that previously led to the employee-beneficiary's cancellation or termination. Nothing in this Rule shall be deemed to require the Fund to re-enroll any employee-beneficiary whose enrollment has been previously cancelled or terminated.

(b) Contribution Shortage Cancellation. If an employee-beneficiary's enrollment in the Fund's benefit plan or plans has been cancelled under Rule 4.12 (c), the employee-beneficiary's enrollment in such benefit plan or plans may be reinstated if the employee-beneficiary makes full payment of all contributions due from the employee-beneficiary by the date specified in the contribution shortage notice provided for in Rule 4.11. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. However, if the employee-beneficiary fails to pay all contribution shortages by the date specified in the contribution shortage notice provided for in Rule 4.11, the employee-beneficiary will suffer a break in coverage and may only apply for a new enrollment at the next open enrollment as per Rule 4.14 (a).

5.00 HEALTH AND OTHER BENEFIT PLANS

5.01 Enrollment; Effective Dates of Coverage

(a) New Employee. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary is first hired as an employee. The effective date of coverage shall be the date the employee beneficiary is first hired.

(b) Newly Eligible Employee. An employee-beneficiary, other than a retired member, may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary first becomes an employee due to a change in employment status. The effective date of coverage shall be the date the change in employment status occurs.

(c) Loss of Coverage in a Benefit Plan Offered by the Fund. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for dependent-beneficiaries when the employee-beneficiary loses coverage under the benefit plans offered or sponsored by the Fund because the employee-beneficiary's covering enrollment was terminated or the employee-beneficiary ceased to be eligible as a dependent-beneficiary. The effective date of coverage shall be the day of the employee-beneficiary's loss of coverage.

(d) Loss of Coverage in a Non-Fund Health Benefit Plan. An employee-beneficiary who is eligible but not enrolled, may enroll in the health benefit plans offered or sponsored by the Fund, and obtain coverage for eligible dependent-beneficiaries, when the employee-beneficiary meets the

conditions required for a special enrollment under 26 U.S.C. §9801(f) and the federal regulations enacted under or pursuant to that statute. These conditions are:

(1) At the time that coverage under the Fund's health benefit plans were offered to the employee-beneficiary, the employee-beneficiary was covered by a Non-Fund health benefit plan or a COBRA continuation provision; and

(2) The employee-beneficiary declined coverage under the Fund's health benefit plans because of the employee-beneficiary's coverage under the Non-Fund health benefit plan or a COBRA continuation provision; and

(3) The employee-beneficiary's coverage under the Non-Fund health benefit plan was terminated as a result of loss of eligibility for that coverage (including as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment) or because employer contributions towards such coverage was terminated; or

(4) The employee-beneficiary's coverage under the COBRA continuation provision was exhausted.

The effective date of the coverage under Rule 5.01(d) shall be as follows: If a properly completed enrollment form is filed within thirty (30) days of the date that the employee-beneficiary loses coverage or the date that the employee-beneficiary's COBRA continuation coverage is exhausted, whichever event is applicable, the effective date of coverage will be the date of that event. If a properly completed enrollment form is filed more than thirty (30) days after the event, the effective date of coverage will be the first day of the pay period after the form is received.

(e) Enrollment Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary who has previously declined coverage in the health benefit plans offered or sponsored by the Fund may enroll in the Fund benefit plans when the employee-beneficiary gains a dependent through a change in marital, domestic partnership or family status, e.g., marriage, entry into domestic partnership, birth, adoption, or issuance of a qualified medical child support order. The effective date of enrollment shall be:

(1) The date the Fund receives proper notification of the change in marital, domestic partnership or family status; or

(2) The date of a child's birth, adoption, or placement for adoption.

(f) Enrollment or Changes in Enrollment Upon Retirement. An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when that person begins to receive a retirement allowance from a state or county retirement system. The effective date of the coverage shall be the employee-beneficiary's date of retirement.

(g) Surviving Spouse, Domestic Partner, or Child of a Deceased Retiree or an Employee Who was Killed in the Performance of Duty. A surviving spouse, domestic partner or unmarried child who is eligible as an employee-beneficiary under Rule 3.01(a) may enroll in the health benefit plans offered or sponsored by the Fund. The effective date of coverage shall be determined under Rule 4.08, the date of the event that permits enrollment being the date that the retiree deceases or the date that the employee is killed in the performance of duty, whichever is applicable.

(h) The public employer's contribution and employee-beneficiary's contribution, if any, shall begin on the first day of the pay period immediately following the employee-beneficiary's effective date of coverage in the health benefit plans.

5.02 Changes in Enrollment; Effective Dates of Coverage

(a) Additions of Dependents Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary may change his or her enrollment to add coverage for dependent-beneficiaries in the Fund health benefit plans in which the employee-beneficiary is currently enrolled upon the occurrence of any of the following events: marriage, entry into domestic partnership, birth of a child, adoption of a child, addition of a foster child, or the issuance of a qualified medical support order. The effective date of the change in enrollment shall be:

(1) The date that the Fund receives proper notification of the addition of the spouse, foster child, or other dependent-eligible; or
(2) In the case of the birth of a child, the date of the child's birth; or
(3) In the case of the adoption of a child at birth, the date of the child's birth, provided that the employee-beneficiary provides the Trust Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment

application for the child prior to the child's birth or within thirty days thereafter; or

(4) In the case of the adoption of a child after birth, the date of the adoption, provided that the employee-beneficiary provides the Fund with satisfactory documents evidencing the adoption and an enrollment application for the child within thirty days of the date of adoption; or

(5) In the case of a child placed for adoption, the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, provided that the employee-beneficiary provides the Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment application for the child within thirty days of the date that the employee-beneficiary assumes custody of and an obligation to support the child; or

(6) In the case of a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

Notwithstanding Rule 5.02(a) (5), the effective date of coverage for a child placed for adoption may be any other date that is specified: in an applicable court order, by a government agency placing the child, or by a licensed child placing organization placing the child. Except as otherwise required by law or these rules, Rule 4.05 shall apply to changes of enrollment under this Rule.

(b) Deletions of Dependents Due to Changes in Marital, Domestic Partner or Family Status. An employee-beneficiary shall change his or her enrollment to terminate coverage of dependent-beneficiaries who cease to be eligible for continued enrollment in the Fund health benefit plans upon the occurrence of any of the following events: divorce or dissolution; annulment; legal separation; dissolution or other act ending domestic partnership; death of a spouse, domestic partner or child; failure to complete the adoption of a child; the end of any required coverage of a child under a qualified medical support order; or a child ceases to be eligible for coverage as a dependent-beneficiary under Rule 3.01(b). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Employee-beneficiaries and dependent-beneficiaries are required to provide the Fund with written notice of the occurrence of these events as soon as reasonably practicable pursuant to Rule 4.06 and Rule 4.13(c).

(c) Loss of Spouse's or Domestic Partner's Coverage. An employee-beneficiary may change enrollment to add a spouse or domestic partner as a dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the employee-beneficiary's spouse or domestic partner has lost coverage in any health benefit plan due to an employment termination or other loss of eligibility. The effective date of the change in enrollment shall be the date that the employee-beneficiary's spouse or domestic partner lost coverage in the spouse's or domestic partner's health benefit plan.

(d) Last Child Becomes Ineligible. An employee-beneficiary may change his or her enrollment in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the last of the employee-beneficiary's children becomes ineligible for coverage as a dependent-beneficiary under the health benefit plans offered or sponsored by the Fund, e.g., when the child marries, becomes nineteen years of age and is not a full-time student, is between nineteen and twenty-four years of age and ceases to be a full-time student, or becomes twenty-four years of age. The effective date of the change in enrollment shall be the date on which the child lost eligibility.

Notwithstanding Rule 4.06, if the employee-beneficiary fails to give the appropriate notice to the Fund within thirty days of the event, the effective date of the change in coverage shall be the date on which notice was received by the Fund.

(e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:

(1) The employee-beneficiary moves to a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan. The effective date of the change shall be the date of the employee-beneficiary's relocation.

(2) The employee-beneficiary is enrolled in a supplemental health benefits plan offered or sponsored by the Fund and loses primary coverage in a Non-Fund health benefits plan. The effective date of the change shall be the date that the employee-beneficiary loses coverage in the Non-Fund health benefits plan.

(f) Any change in the public employer's contribution and the employee-beneficiary's contribution resulting from the change in enrollment or coverage shall be effective on the first day of the pay period immediately following the effective date of the employee-beneficiary's change in enrollment or coverage.

5.03 Mandatory Enrollment in Medicare Part B for Retired Employees

(a) An employee-beneficiary or a dependent-beneficiary shall submit a Notice of Enrollment along with proof of enrollment in the federal Medicare Part B medical insurance plan when the employee-beneficiary or dependent-beneficiary becomes eligible to enroll in the federal Medicare Part B medical insurance plan. Notwithstanding Rule 4.05, the effective date of coverage shall be the later of the following:

(1) The date that the employee-beneficiary or dependent-beneficiary becomes eligible for Medicare provided that proof of enrollment in Medicare Part B is submitted; or
(2) The first day of the month in which the Fund receives the employee-beneficiary or dependent-beneficiary's enrollment application and proof of enrollment in Medicare Part B.

(b) Each public employer shall pay to the Fund a contribution equal to $50 per month, or such other amount as is determined by the board, for voluntary medical insurance coverage under Medicare for retired members of the employees' retirement system, county pension system, or a police, firefighters, or bandsmen pension of the State or a county as set forth in Chapter 88 of the Hawaii Revised Statutes. Out of such contributions, the Fund shall reimburse the premiums paid, exclusive of any and all Medicare penalties, by the following persons for Medicare Part B medical insurance coverage in the amount of $50 per month or such other amount as is determined by the board:

(1) An employee-beneficiary who is a retired employee;
(2) The employee-beneficiary's spouse or domestic partner while the employee-beneficiary is living; and
(3) The employee-beneficiary's spouse or domestic partner after the death of the employee-beneficiary, if the spouse or domestic partner qualifies as an employee-beneficiary under Rule 3.01(a).

Payment of these reimbursements shall be made only for those persons who are enrolled in the Medicare Part B medical insurance plan and pay their Medicare Part B medical insurance premiums to the Social Security Administration.

5.04 Cancellation Due to Failure to Enroll in Medicare; Effective Date of Cancellation

(a) If an employee-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be cancelled.

(b) If a dependent-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the dependent-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund shall be cancelled.

(c) The effective date of any cancellation under this rule shall be the date upon which the employee-beneficiary or dependent-beneficiary, as applicable, first became eligible to enroll in the federal Medicare Part B medical insurance plan.

5.05 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Surviving Spouse's or Domestic Partner's Remarriage or Entry into Domestic Partnership. A surviving spouse's or domestic partner's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. The effective date of the termination shall be the first day of the pay period following the date of the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. Notwithstanding the foregoing, the child of a deceased retiree that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(6) may continue his or her coverages by filing an enrollment application under Rule 5.01(g). The effective date of coverage shall be as provided in Rule 4.08(b), the date of the event making the person eligible for enrollment being the date of termination of coverage due to the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership.

(b) Termination Due to Child's Loss of Eligibility. A child's enrollment in all benefit plans offered or sponsored by the Fund shall be terminated upon the occurrence of any of the following events:

(1) The child marries;
(2) The child enters active military duty;
(3) The child reaches the age of nineteen and is not a full-time student;
(4) The child is between the ages of nineteen and twenty-four and ceases to be a full-time student;
(5) The child, while still a full-time student, reaches the age of twenty-four; or
(6) The employee-beneficiary fails to complete a legal adoption of the child within twelve months of the date that the child is covered by the Fund's benefit plans.

Notwithstanding Rule 5.05 (b) (6), the enrollment of a child placed for adoption shall not be terminated if the employee-beneficiary has custody of and an obligation to support the child under a court order or agreement with a government agency or licensed child placing organization.

With respect to subsections (1) and (2), the loss of eligibility as a dependent-beneficiary is permanent. Unless provided otherwise by these rules or applicable federal or state law, the effective date of the termination shall be the first day of the pay period following the date of the event or, in an event under Rule 5.05 (b) (6), the date stated in a written notice to the employee-beneficiary.

5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

(a) Reinstatement in Employment. If as a result of an order or award from a court, arbitrator or other entity with proper jurisdiction over the matter, an employee-beneficiary is found to have been wrongfully terminated or suspended and is ordered to be reinstated in state or county employment, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which the employee-beneficiary's coverage was terminated. The effective date of the reinstatement shall be the date of termination so that the employee-beneficiary's coverage is continuous, provided that the employee-beneficiary pays the full cost of such coverage less any contribution paid by the employer on behalf of the employee-beneficiary as provided by statute, the employer's administrative rules, or an

applicable bargaining unit agreement. If the full cost of such coverage is not paid, the reinstatement shall be effective upon the employee-beneficiary's return to active duty.

(b) Return From an Authorized Leave of Absence. If an employee-beneficiary returns from an authorized leave of absence ("LOA") during which coverage was not provided by a Fund benefit plan, the employee-beneficiary may be reinstated in the same Fund benefit plans from which coverage was cancelled if the employee-beneficiary files a properly completed enrollment application. In accordance with Rule 4.05, the reinstatement shall be effective upon the employee-beneficiary's return from the LOA if the employee-beneficiary files the enrollment application within thirty days of his or her return from the LOA.

(c) Return From a Leave of Absence Covered by the Family Medical Leave Act (FMLA) Or Uniform Services Employment and Reemployment Rights Act (USERRA). If an employee-beneficiary returns from a leave of absence covered under the FMLA or USERRA and the employee-beneficiary's enrollment in the Fund benefit plans was canceled during that leave of absence, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which coverage was canceled. The reinstatement shall be effective upon the employee-beneficiary's return to work.

(d) Enrollment in Medicare by a Retired Employee. If the enrollment of an employee-beneficiary or the coverage of a dependent-beneficiary was terminated due to the employee-beneficiary's or dependent-beneficiary's failure to enroll in the federal Medicare Part B medical insurance plan, upon the employee-beneficiary's or dependent-beneficiary's enrollment in such plan and submission of a proper and complete enrollment application to the Fund, the employee-beneficiary or dependent-beneficiary shall be enrolled in or covered by the Medicare supplemental plan offered by the Fund. The coverage shall be effective on the date specified in Rule 5.03.

(e) The employer's contribution and the employee-beneficiary's contribution shall begin on the first day of the pay period immediately following the employee-beneficiary's effective date of coverage.

The Hawaii Employer-Union Health Benefits Trust Fund Board of Trustees Administrative Rules were adopted during a regular meeting of the Board of Trustees on February 19, 2003, which were amended and approved on May 19, 2004, August 25, 2004, September 28, 2005, March 22, 2006, September 26, 2007, and August 20, 2008. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.

Marie Laderta, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED

Linda Lingle
Governor
State of Hawaii

Date Filed, Office of the Lieutenant
Governor

'09 APR -9 P12:19

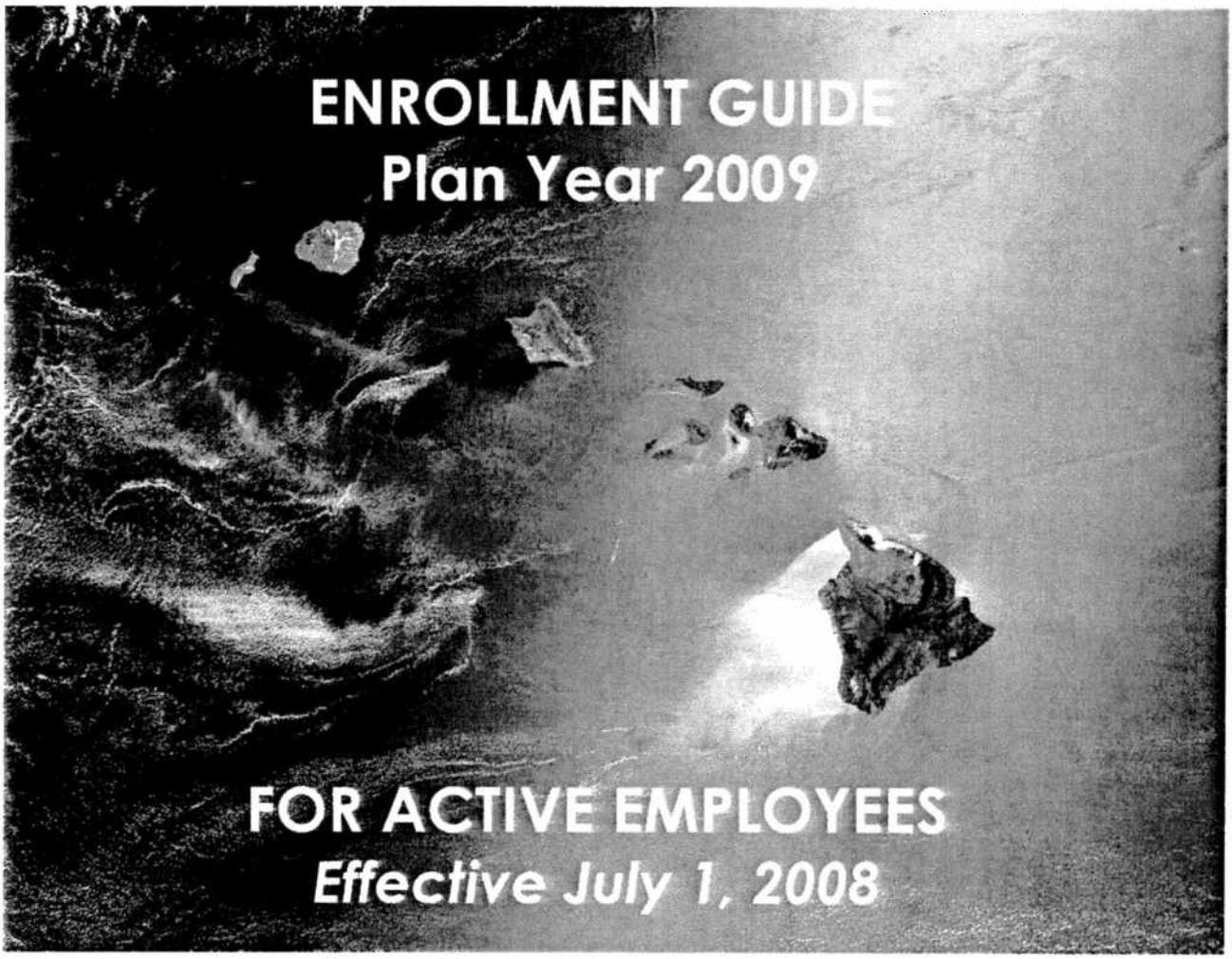
LIEUTENANT GOVERNOR
OFFICE

APPROVED AS TO FORM:

Deputy Attorney General

Appendix M
EUTF Reference Guides

Hawaii
Employer-Union Health Benefits Trust Fund (EUTF)



Open Enrollment: April 14 to May 14, 2008
Benefit Fairs: April 14 to May 9, 2008
Election Form Deadline: May 14, 2008

TABLE OF CONTENTS

Attention: Medicare Eligible Members

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. The EUTF sponsored prescription drug plan, except for the supplemental plans, offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. Your Notice of Creditable Coverage is on page 19.

If you are enrolled in the supplemental medical plan, your prescription drug coverage is considered to be non-creditable when compared to the standard Medicare Part D plan. Please refer to the Notice of Non-Creditable Coverage that begins on page 21.

WELCOME!

This is your Open Enrollment Guide for the 2009 Plan Year. Please follow the instructions in this guide carefully. Take the time to review the plan options available to you. If you are making any changes, be sure to turn in your election forms by **May 14th, 2008.**

Note: If you have made or submitted any changes since February 1, 2008, your changes may not be reflected on the benefit notice which lists your current benefit plan enrollments. You may contact the EUTF to verify any changes submitted after that date.

HIGHLIGHTS FOR PLAN YEAR 2009 (July 1, 2008 through June 30, 2009)

Plan	Carrier	Benefit Changes
Medical	HMA	No Change
	HMSA	Minor language clarifications and administrative changes eff. 7/1/08
	Kaiser	Please see Page 9 for details
	Royal State National	No Change
Chiropractic	Royal State National	No Change
Prescription Drug	NMHC	No Change
Dental	HDS	No Change
Vision	VSP	No Change
Life Insurance	Standard	No Change

IMPORTANT: OPEN ENROLLMENT DATES

Open Enrollment is from April 14, 2008 to May 14, 2008.

Effective date for changes will be July 1, 2008.

Each active employee is receiving this guide along with an open enrollment benefit notice that contains the information that the EUTF had as of March 1, 2008. Each employee is asked to review the information for accuracy. If you have any changes, please complete an EC-1, Enrollment Change form with your selections and submit the form to your personnel office.

Special Note for New or Newly-eligible Employees

If you became eligible for benefits as a new or newly-eligible employee during the months of February, March or April, you may not have received the open enrollment benefit notice which lists your current benefit plan enrollments. If you want to make changes to your plans, coverage or dependents, you will need to submit an EC-1 during the open enrollment period to make these changes. You can get an EC-1 from the EUTF website or from your personnel office.

If you were hired in May or June, 2008, you also should have received instructions from your employer to enroll for the subsequent plan year that begins on July 1, 2008. Please check with your personnel office for more information or contact the EUTF for assistance.

OPEN ENROLLMENT INSTRUCTIONS

Step 1: Review the choices available to you and decide whether you want to change or keep your plans. Review the Plan Comparison Charts which summarize plan benefits beginning on page 12.

Step 2: If you have questions about your plan choices, please attend a Benefit Fair.

During Open Enrollment, all State and county employees are invited to explore healthcare and insurance options at the Benefit Fairs. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMA HMSA Kaiser Royal State National
Chiropractic plan:	Royal State National
Prescription Drug plan:	NMHC
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	Standard Insurance Company

Step 3: Review your Open Enrollment materials and the Summary of Benefits on page 12 of this guide.

If you want more specific information regarding the different plans, please contact the applicable insurance carrier for your personal copy of their plan details. You can access the EUTF website, www.eutf.hawaii.gov for the latest information regarding the open enrollment.

Step 4: **Make your selections on the EC-1 form and submit the completed and signed form to your agency/department open enrollment designee no later than May 14, 2008.**

The designee may be your office secretary, financial officer, human resources personnel—find out who has been designated by your agency/department. It is very important that you submit your completed form on time.

A: To make any changes to your personal information, simply complete the corrected information on the EC-1 form.

B: To make changes to your plan or coverage, make your selections on the EC-1, Enrollment Change form, and submit the completed and signed form to your designated open enrollment contact.

C: To add a dependent, enter the appropriate information in the dependents section.

NOTE: You will notice that your benefit notice does not include your social security number. The HB number is your EUTF ID number. You will need to provide this ID number when communicating with the EUTF. If you are adding a new dependent, you are required to submit your dependent's social security number at the initial enrollment.

IT IS ABSOLUTELY CRITICAL THAT YOU SUBMIT ANY CHANGES TO YOUR PERSONNEL OFFICE NO LATER THAN MAY 14, 2008. Forms submitted after May 14, 2008 will be rejected.

Step 5: The EUTF will forward your enrollment confirmation notice by the end of June 2008. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. You may make corrections to your enrollment that you submitted on the EC-1 enrollment form. **NO CHANGES TO YOUR ORIGINAL SELECTIONS WILL BE ALLOWED AFTER May 14, 2008.** Only corrections will be accepted after May 14, 2008!

If you want to change your benefits or make other changes:

You must make changes during the open enrollment period if:

- You want to choose a different benefit plan
- You want to change coverage for dependents

You can add dependents, including spouse, children or a domestic partner (DP) to your plan during open enrollment. To add a DP to your plan, please contact the EUTF to obtain the documents required to enroll a DP or go to the EUTF website, www.eutf.hawaii.gov, to download the appropriate forms.

Remember, under EUTF rules, employees are required to notify the EUTF of changes in dependent eligibility. Failure to do so may result in loss of premiums and additional benefit rights, such as COBRA, for dependents.

IMPORTANT: If any of your dependents are deleted due to a divorce, or becoming ineligible due to age or loss of student status, do not submit these deletions with your open enrollment changes. These changes should be reported when the event occurs.

Monthly Premiums and Employer/Employee Contributions

Carrier or Administrator	Type of Plan	Coverage	Premiums Except BU 7 & BU 12*	Employer Contribution	Employee Contribution
EUTF PPO (HMA) NMHC Drug RSN Chiropractic	PPO Medical, Drugs, and Chiropractic	Self	$274.78	$169.22	$105.56
		Two Party	$666.68	$410.20	$256.48
		Family	$850.46	$523.72	$326.74
EUTF PPO (HMSA) NMHC Drug RSN Chiropractic	PPO Medical, Drugs, and Chiropractic	Self	$280.20	$169.22	$110.98
		Two-Party	$679.82	$410.20	$269.62
		Family	$867.24	$523.72	$343.52
EUTF HMO (HMSA) Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$302.56	$169.22	$133.34
		Two-Party	$734.06	$410.20	$323.86
		Family	$936.44	$523.72	$412.72
Kaiser Comprehensive Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$292.30	$169.22	$123.08
		Two-Party	$708.76	$410.20	$298.56
		Family	$904.64	$523.72	$380.92
Kaiser Basic Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$261.10	$169.22	$91.88
		Two-Party	$632.96	$410.20	$222.76
		Family	$807.92	$523.72	$284.20
HMSA Supplemental NMHC Drug RSN Chiropractic	Supplemental Medical, Drugs, and Chiropractic	Self	$167.00	$101.30	$65.70
		Two-Party	$405.14	$245.38	$159.76
		Family	$516.84	$313.48	$203.36
Royal State Supplemental RSN Drug RSN Chiropractic	Supplemental Medical, Drugs, and Chiropractic	Self	$56.62	$35.06	$21.56
		Two-Party	$139.74	$86.14	$53.60
		Family	$157.40	$97.82	$59.58
EUTF High Deductible Health Plan (HMSA) Prescription Drug	PPO Medical and Drugs	Self	$206.34	$169.22	$37.12
		Two-Party	$500.62	$410.20	$90.42
		Family	$638.62	$523.72	$114.90
EUTF Prescription Drugs Only (NMHC)	Prescription Drugs Only	Self-only	$53.64	$32.42	$21.22
		Two-Party	$130.14	$78.60	$51.54
		Family	$166.02	$100.36	$65.66
HDS	Dental	Self	$28.24	$17.06	$11.18
		Two-Party	$56.54	$34.18	$22.36
		Family	$93.02	$70.66	$22.36
VSP	Vision	Self	$6.04	$3.64	$2.40
		Two-Party	$11.18	$6.76	$4.42
		Family	$14.62	$8.84	$5.78
Standard Insurance	Life Insurance	Employee	$4.16	$4.16	None

*BU 7 and BU 12 employees should contact their employer or go to the EUTF website (www.eutf.hawaii.gov) for information regarding their premiums and contributions.

FOR ALL EUTF Active Participants and Retirees			
Date	**Presentation Time**	**Facility**	**Location**
14-April	8:30 – 10:30 a.m.	U.H. Kuykendall Auditorium	University of Hawaii
14-April	1:00 – 3:00 p.m.	U.H. Kuykendall Auditorium	University of Hawaii
15-April	8:30 – 10:30 a.m.	LCC (GT 105)	Leeward Community College
15-April	1:00 – 3:00 p.m.	LCC (GT 105)	Leeward Community College
16-April	8:30 – 10:30 a.m.	Kapolei Hale (CF A&B)	Kapolei
16-April	1:00 – 3:00 p.m.	Kapolei Hale (CF A&B)	Kapolei
17-April	8:30 – 10:30 a.m.	LCC (GT 105)	Leeward Community College
17-April	1:00 – 3:00 p.m.	LCC (GT 105)	Leeward Community College
18-April	8:30 – 10:30 a.m.	Maui Okinawa Cultural Center	Wailuku
18-April	1:00 – 3:00 p.m.	Maui Okinawa Cultural Center	Wailuku
21-April	9:00 – 11:00 a.m.	War Memorial Convention Center (Hall)	Lihue
21-April	1:00 – 3:00 p.m.	War Memorial Convention Center (Hall)	Lihue
23-April	8:30 – 10:30 a.m.	Kapolei Hale (CF A&B)	Kapolei
23-April	1:00 – 3:00 p.m.	Kapolei Hale (CF A&B)	Kapolei
23-April	8:30 – 10:30 a.m.	WCC (Akoakoa 101&103)	Windward Community College
23-April	1:00 – 3:00 p.m.	WCC (Akoakoa 101&103)	Windward Community College
24-April	10:00 – 12:00 p.m.	Honokaa High School (Cafeteria)	Hilo
25-April	8:30 – 10:30 a.m.	Maui Okinawa Cultural Center	Wailuku
25-April	1:00 – 3:00 p.m.	Maui Okinawa Cultural Center	Wailuku
28-April	9:00 – 11:00 a.m.	Kona Armory	Kealakekua-Kona
28-April	1:30 – 3:30 p.m.	Kona Liquor Control Office	Kailua-Kona
29-April	9:00 – 11:00 a.m.	War Memorial Convention Center (Hall)	Lihue
29-April	1:00 – 3:00 p.m.	War Memorial Convention Center (Hall)	Lihue
30-April	9:00 – 11:00 a.m.	Aunt Sally's Lu'au Hale	Hilo
30-April	1:00 – 3:00 p.m.	Aunt Sally's Lu'au Hale	Hilo
1-May	9:00 – 11:00 a.m.	Aunt Sally's Lu'au Hale	Hilo
1-May	1:00 – 3:00 p.m.	Aunt Sally's Lu'au Hale	Hilo
5-May	8:30 – 10:30 a.m.	State Capitol Auditorium	Honolulu
5-May	1:00 – 3:00 p.m.	State Capitol Auditorium	Honolulu
6-May	8:30 – 10:30 a.m.	State Capitol Auditorium	Honolulu
6-May	1:00 – 3:00 p.m.	State Capitol Auditorium	Honolulu
7-May	8:30 – 10:30 a.m.	State Capitol Auditorium	Honolulu
7-May	1:00 – 3:00 p.m.	State Capitol Auditorium	Honolulu
8-May	8:30 – 10:30 a.m.	U.H. Kuykendall Auditorium	University of Hawaii
8-May	1:00 – 3:00 p.m.	U.H. Kuykendall Auditorium	University of Hawaii
9-May	8:30 – 10:30 a.m.	WCC (Akoakoa 101&103)	Windward Community College
9-May	1:00 – 3:00 p.m.	WCC (Akoakoa 101&103)	Windward Community College
9-May	8:30 – 10:30 a.m.	LCC (GT 105)	Leeward Community College
9-May	1:00 – 3:00 p.m.	LCC (GT 105)	Leeward Community College

Benefit Fair Locations

HAWAII

Aunt Sally's Lu'au Hale
799 Piilani Street
Hilo, HI 96720

Department of Defense, Kona Armory
81-1032 Nani Kupuna Road
Kealakekua-Kona, HI 96740

Honokaa High School
45-527 Pakalana Street
Honokaa, HI 96727

Kona Liquor Control Office
75-5722 Hanama Place, #1107
Kailua-Kona, HI 96740

KAUAI

War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

MAUI

Maui Okinawa Cultural Center
688 Nukuwai Street
Wailuku, HI 96793

OAHU

Leeward Community College
96-045 Alaike Street
Pearl City, HI 96782

Kapolei Hale, Conf Rm A, B, & C.
1000 Uluohia Street
Kapolei, HI 96707

U.H. Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

Windward Community College
45-720 Keaahala Road
Kaneohe, HI 96744

CHOICES FOR PLAN YEAR 2009

All plan benefits will remain unchanged for the 2009 Plan Year, except as noted below for HMSA and Kaiser.

Medical Health Plan Options **See Page 12 for plan comparisons**

Preferred Provider Organization Options: **EUTF PPO Medical (HMA), EUTF Drug (NMHC) & RSN Chiropractic**
EUTF PPO Medical (HMSA), EUTF Drug (NMHC) & RSN Chiropractic

A Preferred Provider Organization (PPO) is a medical plan that provides a higher benefit if you visit doctors that are part of the plan's network. If you decide to see a physician who is not a member of the plan's network, benefits will be at a reduced level. Most PPO plans, including the ones offered to you by the EUTF, require coinsurance or co-payments for services. HMSA has made minor language clarifications and administrative changes that are effective July 1, 2008.

Health Maintenance Organization Options: **Kaiser Comprehensive, Prescription Drug & RSN Chiropractic**
Kaiser Basic, Prescription Drug & RSN Chiropractic
EUTF HMO (HMSA Medical &Drug) & RSN Chiropractic

A Health Maintenance Organization (HMO) is a medical plan that allows you to visit doctors only within a specific network. HMOs usually charge a minimal co-payment for services. HMSA has made minor language clarifications and administrative changes that are effective July 1, 2008.

Plan Changes (Effective July 1, 2008):

- Kaiser Comprehensive Option:
    - The co-payment for emergency services received within the Hawaii service area will increase from $25 to $50 per visit.
    - The supplemental charges maximum will increase from $1,500/$4,500 to $2,000 per member and $6,000 per family unit (of three or more members) per calendar year.
    - The co-payment for immunizations will be no charge for members who are 18 years of age and under and $10 per dose for members who are 19 years of age and over. However, the co-payment for flu and pneumococcal immunizations will be no charge.
- Kaiser Basic Option:
    - The co-payment for emergency services received within the Hawaii service area will increase from $25 to $75 per visit.
    - The supplemental charges maximum will increase from $1,500/$4,500 to $2,000 per member and $6,000 per family unit (of three or more members) per calendar year.
    - The co-payment for immunizations will be no charge for members who are 18 years of age and under and $10 per dose for members who are 19 years of age and over. However, the co-payment for flu and pneumococcal immunizations will be no charge.
- Molokai and Lanai:
    - Kaiser Permanente will have clinicians based on the islands of Molokai and Lanai. Please contact Kaiser's Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) for more information.

High Deductible Health Plan Option: **EUTF HDHP (HMSA Medical and Drug)**

A High Deductible Health Plan (HDHP) is a medical plan that functions much like a PPO, but has a high deductible that must be satisfied before many benefits are payable. Some benefits, like preventive care, are payable before the deductible is met. An individual enrolled in the HDHP is eligible to open a Health Savings Account (HSA). Pre-tax contributions made to an HSA can be used to pay medical expenses until the calendar year deductible is satisfied. With tax-free savings that roll over year after year, an HSA is an attractive vehicle for funding medical costs and even retirement savings for some people. Also, individuals desiring only catastrophic coverage can enjoy lower monthly costs. This is explained in greater detail beginning on ***page15.***

Prescription Drug Plan: **EUTF Prescription Drug Plan (NMHC)**

The EUTF's prescription drug plan is administered by National Medical Health Card (NMHC). This plan is the prescription drug coverage for the PPO options, administered by HMA and HMSA, for the supplemental medical plan administered by HMSA, and for stand-alone drug coverage.

Supplemental Medical Plans: **EUTF Supplemental (HMSA), EUTF Drug (NMHC) & RSN Chiropractic**
Royal State Supplemental, RSN Drug & RSN Chiropractic

Supplemental Medical Plans are intended to pay expenses that are not covered by another, primary medical plan. If you have a medical plan through your spouse or another source, you can choose these plans to cover any co-payments or coinsurance charged by that plan. This means most likely you would have no out-of-pocket expenses, though you would have additional premiums for the plan. You can enroll in a supplemental plan only if you have another medical plan coverage not provided through the State or counties.

Chiropractic: **Royal State National (RSN)**

Services for this benefit are provided by ChiroPlan Hawaii. The plan benefits include the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. The co-payment is $15 per visit up to 20 visits per calendar year. Chiropractic services must be received by a credentialed ChiroPlan Provider.

- The chiropractic benefit is packaged with all active medical plans except the High Deductible Health Plan.

Dental: **Hawaii Dental Service (HDS)**

Your plan provides:

- 100% coverage for diagnostic and preventive services
- 80% coverage for basic services such as fillings, root canals and oral surgery
- 60% coverage on all major work such as crowns, bridges and dentures
- Your deductible is $50 per plan year, beginning July 1st of each year
- Services covered at 100% are not subject to the deductible
- The plan maximum is $2,000 per plan year, beginning July 1st of each year
- Your plan will also pay up to $1,000 for orthodontic services

Vision: **Vision Service Plan (VSP)**

Your Coverage from a VSP Doctor

Exam covered in full every plan year[1], after a $10 Copay

Prescription Glasses

Lenses covered in full every plan year[1], after a $25 Copay

Frame every other plan year[1]

- Up to $120, plus 20% off any out-of-pocket costs

~OR~

Contact Lenses every plan year[1]

- $120 allowance

Extra Discounts and Savings available

- Glasses and Sunglasses
- Contacts
- Laser Vision Correction

Dollar for dollar, you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You will also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call VSP first at 800-877-7195.

[1]Plan year begins in July.

Life Insurance: **Standard Insurance Company**

Your life insurance benefit remains at $36,225, for active participants. Since this benefit is fully paid by employers for all eligible employees and the coverage is the same for everyone, you do not need to make an election for this coverage.

- Your benefit will reduce once you reach age 65 and continue to reduce as follows:
  - $23,546 for participants age 65 through 69
  - $16,301 for participants age 70 through 74
  - $10,868 for participants age 75 through 79
  - $7,245 for participants age 80 and over

In addition, your life insurance includes the following added benefits:

- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of remains benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.
- Travel assist benefit – helps you respond to medical care situations when you are 100 miles or more away from home.

SUMMARY OF BENEFITS

THIS COMPARISON IS A SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN. Benefits will be administered as described in each plan's documents. For further information contact the carrier.

Plan Provisions	PPO In-Network (HMA & HMSA)	PPO Out-of-Network (HMA & HMSA)	Kaiser Comprehensive	Kaiser Basic	HMO (HMSA)	HDHP (HMSA) In-Network	HDHP (HMSA) Out-of-Network	Supplemental (Royal State)	Supplemental (HMSA)
General									
Deductible Single/Family[1]	None[2]	$100/$300	None/None	None/None	None/None	$1,500/ $3,000	$1,500/ $3,000	None	None
Out-of-pocket limit Single/Family[1]	$2,000/ $6,000	$2,000/ $6,000	$2,000/ $6,000	$2,000/$6,000	$1,500/ $4,500	$4,000/ $8,000	$4,000/ $8,000	None	$10,000
Lifetime Benefit Maximum	None	None	None	None	None	$2,000,000	$2,000,000	None	$1,000,000
Policy Year Benefit Maximum	None	None	None	None	None	None	None	Medical Services: $3,000; Rx: $100/$300	None
Physician Services									
Primary Care Office Visit	10%	30%	$15	$25	$15	10%	30%	Co-pay covered	50%
Specialist Office Visit	10%	30%	$15	$25	$15	10%	30%	Co-pay covered	50%
Routine physical exams	No Charge	No Charge*	$15	$25	$15	No Charge	No Charge	Co-pay covered	Not Covered
Screening Mammography	10%	30%*	No Charge	No Charge	No Charge	No Charge	30%	Co-pay covered	In-network - No Charge; Out-of-Network - 50%
Immunizations	No Charge	No Charge*	No charge or $10	No charge or $10	No Charge	No Charge	No Charge	Co-pay covered	50%
Well Baby Care Visits	No Charge	30%*	$15	$25	$15	No Charge	30%	Co-pay covered	In-network - No Charge; Out-of-Network - 50%
Maternity	Same as any other condition	Same as any other condition	Routine OB care: no charge, after confirmation of pregnancy	No Charge, after confirmation of pregnancy	No Charge, Routine Pre/Post Natal Care & Delivery	Same as any other condition	Same as any other condition	Co-pay covered	Same as any other condition

[1] Per Calendar Year.
[2] Except for Nutritional Counseling.
* Deductible does not apply.

THIS COMPARISON IS ONLY A SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN. Benefits will be administered as described in each plan's documents. For further information contact the carrier.

Plan Provisions	PPO In-Network (HMA & HMSA)	PPO Out-of-Network (HMA & HMSA)	Kaiser Comprehensive	Kaiser Basic	HMO (HMSA)	HDHP (HMSA) In-Network	HDHP (HMSA) Out-of-Network	Supplemental (Royal State)	Supplemental (HMSA)
Second opinion – surgery	10%	30%	$15	$25	$15	10%	30%	Co-pay covered	50%
Emergency Room (ER care)	10%	10%*	$50	$75	$25 (in-state $25 Bluecard) 20% (worldwide)	10%	10%	Co-pay covered	50%
Ambulance	10%	30%	20%	20%	20%	10%	30%		50%
Inpatient Hospital Services									
Room & Board	10%	30%	No Charge	$100 per day (except routine post-partum days)	No Charge	10%	30%	Co-pay covered	50%
Ancillary Services	10%	30%	$15 per department per day	50%	No Charge	10%	30%	Co-pay covered	50%
Physician services	10%	30%	No Charge	No Charge	No Charge	10%	30%	Co-pay covered	50%
Surgery	10%	30%	No Charge	No Charge	No Charge	10%	30%	Co-pay covered	50%
Anesthesia	10%	30%	No Charge	No Charge	No Charge	10%	30%	Co-pay covered	50%
Outpatient Services									
Chemotherapy /Radiation Therapy	10%	30%	$15	$25	$15	10%	30%	Co-pay covered	50%
Surgery	10%	30%	$15	$25	$15	10%	30%	Co-pay covered	50%
Diagnostic Lab	10%	30%	$15 per department per day	50%	No Charge	10%	30%	Co-pay covered	50%
Diagnostic X-ray	10%	30%	$15 per department per day	50%	$15 per X-ray	10%	30%	Co-pay covered	50%
Anesthesia	10%	30%	No Charge	No Charge	$15	10%	30%	Co-pay covered	50%

THIS COMPARISON IS ONLY A SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN. Benefits will be administered as described in each plan's documents. For further information contact the carrier.									
Plan Provisions	**PPO In-Network (HMA & HMSA)**	**PPO Out-of-Network (HMA & HMSA)**	**Kaiser Comprehensive**	**Kaiser Basic**	**HMO (HMSA)**	**HDHP (HMSA) In-Network**	**HDHP (HMSA) Out-of-Network**	**Royal State Supplemental**	**Supplemental (HMSA)**
Mental Health Services									
Inpatient care	10%	30%	No Charge	20%	No Charge	10%	30%	Co-pay covered	50%
Outpatient Care	10%	30%	$15	20%	$15	10%	30%	Co-pay covered	50%
Other Services									
Durable Medical Equipment	10%	30%	20%	Not Covered	20%	10%	30%	Co-pay covered	50%
Home Health care	No Charge	30%	No Charge	No Charge	No Charge	No Charge	30%	Co-pay covered	50%
Hospice Care	No Charge	Not Covered	No Charge	No Charge	No Charge	No Charge	Not Covered	Co-pay covered	In-network - No Charge; Out-of-Network – Not Covered
Nursing facility - skilled care	10%, 120 days per calendar year	30%, 120 days per calendar year	No Charge, 100 days per calendar year	No Charge, 60 days per calendar year	No Charge, 100 days per calendar year	10%; 120 days per calendar year	30%; 120 days per calendar year	Co-pay covered	50%; 120 days per calendar year
Physical & Occupational Therapy	10%	30%	$15	$25	$15 (Outpatient)	10%	30%	Co-pay covered	50%
Prescription Drugs**	**NMHC**	**NMHC**	**Kaiser**	**Kaiser**	**HMSA**	**HMSA**	**HMSA**	**Royal State**	**NMHC**
Generic co-pay (1st Level)	$5	$5 + 20%	$15	$15	$5 (in network) $5 + 20% (out of network)	$5***	$5*** + 20%	Co-pay covered up to $10 per Rx	All Charges Exceeding Plan Payment of $20
Preferred co-pay (2nd Level)	$15	$15 + 20%	$15	$15	$15 (in network) $15 + 20% (out of network)	$15***	$15*** + 20%	Co-pay covered up to $10 per Rx	All Charges Exceeding Plan Payment of $20
Brand co-pay (3rd Level)	$30	$30 + 20%	$15	$15	$30 (in network) $30 + 20% (out of network)	$30***	$30*** + 20%	Co-pay covered up to $10 per Rx	Not Applicable
90-day mail order	$10 Generic $35 Preferred $60 Other Brand	Not Covered	$30	$30	$10 Generic $35 Preferred $60 Other Brand	$10*** Generic $35 Preferred $60 Other Brand	Not Covered	Co-pay covered up to $10 for each 30 day order	Not Applicable

** Note that the prescription drug benefit for the PPO plans and the EUTF Supplemental plan are administered by National Medical Health Card (NMHC).

*** Note that prescription drug co-payments are not applicable for the high deductible health plan until the deductible is met.

High Deductible Health Plans

High Deductible Health Plans (HDHPs) will give State and county employees more opportunities to save and better manage their hard-earned dollars. With an HDHP, the plan's calendar year deductible must be met before the plan begins paying benefits. There is an exception for preventive care; when you receive preventive care services, such as an annual physical, you will not pay for this service, but a maximum dollar amount may apply.

The EUTF HDHP's **calendar year deductible** is

- $1,500 for self enrollment and
- $3,000 for family enrollment.

The maximum out-of-pocket limits are $4,000 for self enrollment and $8,000 for family enrollment.

Once the calendar year deductible has been satisfied, the health plan will pay most covered benefits at 90%, if you use a network provider. In high deductible health plans, as opposed to other plans, all of the following expenses count toward the out-of-pocket limit:

- the deductible,
- coinsurance, and
- drug co-payments.

Health Savings Account (HSA)

Health Savings Accounts were created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. HSAs are a tax-free savings vehicle for medical expenses. **To have an HSA, you must be enrolled in an HDHP.**

You are responsible for setting up your account. Check with your financial institution. You can use the money in your HSA to pay for qualified medical expenses for you, your spouse, and your dependents. You can also use money in your HSA to pay for expenses subject to the plan's deductible.

How Is Money Put into Your HSA?

You can make voluntary contributions.

Note: Interest can also accrue in your account.

Your account can be funded annually up to $2,900 for self coverage or $5,800 for two-party or family coverage.

Features of an HSA

You can make tax-deductible contributions to your HSA. You have until April 15 of the following year to make your contributions for any tax year.

There is an exception to the maximum annual contribution for individuals between 55 and 65. If you are between the ages of 55 and 65, you can contribute more to your HSA than the normal maximum. These contributions are called "catch up contributions" and you can make them each year beginning at the age of 55 until you reach 65. In 2008, you can make an additional voluntary contribution of $900 to your HSA and every year thereafter that until you reach 65, you can make an additional $1000 contribution.

How Do HSAs Work?

Your voluntary contributions are recorded on your tax form (such as a 1040) as a tax deduction (applies with either itemized or standard deduction). Your contributions can earn tax-free interest and can be used to pay for qualified medical expenses. If you use the money for non-medical expenses, you have to pay regular tax and a 10% tax penalty if you are under age 65. When you use money in your HSA to pay for qualified medical expenses, you do not have to pay taxes on the withdrawal.

The money left in your account at the end of each year (including the interest) is kept in your account for the next year.

If you retire, leave your job or change health plans, your HSA is yours to keep.

Your HSA can be held by a qualified trustee or custodian. You select a trustee or custodian for voluntary contributions. This can be a bank, an insurance company, or a Federal credit union.

You can have the following insurance coverage and still be eligible for an HSA: accident, disability, dental care, vision care, long-term care, specified disease or illness, and insurance that pays a fixed amount per day of hospitalization.

You **can not** have any other comprehensive insurance such as Medicare, TRICARE or TRICARE-for-Life or have used any VA medical services within the past 3 months. You also cannot have a general Health Care Flexible Spending Account. Someone cannot claim you as a dependent on their tax return. If you do not meet the eligibility requirements for an HSA you may still enroll in the HDHP plan but will not be eligible for the tax-free benefits.

Who is responsible for the distribution of funds from the HSA?

It is the individual's responsibility to determine whether HSA distributions are used for qualified medical expenses. In other words, the HSA trustees or custodians do not monitor your distributions to ensure they are being used for qualified medical expenses.

This means that you must maintain records of medical expenses to show that the distributions were used for qualified medical expenses. The IRS may request these records during an audit. The mechanics of distribution from the trustee are plan-specific.

If You or One of Your Dependents Are Eligible for Medicare

Pages 16 through 19 Apply to You

The **Medicare Prescription Drug Program** (Medicare Part D) was established to provide prescription drug coverage for eligible Medicare individuals. Your employer is required to inform you whether or not your prescription drug plan is creditable or non-creditable.

Notice of Creditable Coverage (see page 17)

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan other than a supplemental plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

Notice of Non-Creditable Coverage (see page 18)

If you are enrolled in a supplemental medical plan, the EUTF has determined that your prescription drug benefits are not as good as or better than the standard Medicare Part D drug benefits. As a rule, you are enrolled in the supplemental medical plan because you are also enrolled in another prescription drug plan and you should have received a Notice of Creditable Coverage from that other plan. If your other plan's prescription drug benefits are also non-creditable coverage, you should consider enrolling in Medicare Part D when you first become eligible to do

so. If you don't enroll in Part D when you are first eligible to do so, you may have to pay a penalty (a higher premium) for your Part D coverage when you later do enroll, and you may have to pay that penalty for as long as you are covered under Part D.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

Notice of Creditable Coverage

Important Notice of Creditable Coverage from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with EUTF and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The EUTF has determined that the prescription drug coverage offered by National Medical Health Card (NMHC) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing prescription drug coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. A beneficiary leaving the EUTF coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current medical coverage with the EUTF pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with EUTF and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage, contact our office for further information at (808) 586-7390 or toll free at 1-800-295-0089.

NOTE: You will receive this notice annually and at other times in the future, such as, before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the EUTF changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you later enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: 4/1/08

Name of Entity/Sender: Hawaii Employer-Union Health Benefits Trust Fund

Contact--Position/Office: Customer Service

Address: 201 Merchant Street, Suite 1520, Honolulu HI 96813

Phone Number: 808-586-7390

Notice of Non-Creditable Coverage

Important Notice of Non-Creditable Coverage from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with EUTF and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage in 2006. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The EUTF has determined that the prescription drug coverage offered in its supplemental plans is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Non-Creditable Coverage. Since your enrollment in the supplemental plan indicates that you have another medical plan, that other plan's prescription drug coverage may be as good as or better than the standard Medicare prescription drug coverage. You will need to check with your other plan to find out if this is the case.

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully - it explains your options.

What to Do If You Have Non-Creditable Coverage:

Because the coverage you have with the EUTF'S supplemental plans is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, consider enrolling in a Medicare prescription drug plan.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. A beneficiary leaving the EUTF's coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

This may mean that you will have to wait to enroll in Medicare prescription drug coverage and that you may pay a higher premium (a penalty) if you join later and you will pay that higher premium as long as you have Medicare prescription drug coverage.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your premium will go up at least 1% per month for every month after May 15, 2006, that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without prescription drug coverage that's at least as good as Medicare's, your premium will always be at least 19% higher than what many other people pay.

Your current medical coverage with the EUTF pays for other health expenses in addition to prescription drug expenses. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits through EUTF's supplemental plans.

If you drop your current prescription drug coverage through EUTF's supplemental plans and enroll in Medicare prescription drug coverage through another plan, you may enroll back into an EUTF plan during the open enrollment period under the EUTF-sponsored plans.

When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. For more information, contact us at (808) 586-7390 or toll free 1-800-295-0089.

NOTE: You will receive this notice annually and at other times in the future, such as before the next Medicare prescription drug coverage open enrollment period, and if the EUTF's supplemental plans change. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 4/1/08

Name of Entity/Sender: EUTF

Contact--Position/Office: Customer Service

Address: 201 Merchant Street, Suite 1520, Honolulu HI 96813

Phone Number: 808-586-7390

EUTF Contact Information

Mailing Address:
P.O. Box 2121
Honolulu, HI 96805

Location Address:
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, Hawaii

Local number: 808-586-7390
Toll-Free number: 800-295-0089
Fax number: 808-586-2161

Email address: eutf@hawaii.gov
Website address: www.eutf.hawaii.gov

NEED MORE INFORMATION?

HMA:
Oahu: (808) 951-4694
Toll Free: (866) 331-5913
Monday-Friday: 7:30 AM-5:00 PM

HMSA:
Oahu: (808) 948-6499
Hilo, Hawaii: (808) 935-5441
Kailua-Kona, Hawaii: (808) 329-5291
Kahului, Maui: (808) 871-6295
Lihue, Kauai: (808) 245-3393
Toll Free: (800) 776-4672
Monday-Friday: 8:00 AM-4:00 PM

Kaiser:
Oahu: (808) 432-5955
Toll Free: (800) 966-5955
Monday-Friday: 8:00 AM-5:00 PM
Saturday: 8:00 AM-12:00 PM

Royal State National:
Chiropractic Benefit
Customer Service: (808) 681-4774
Toll-Free: (800) 414-8845
Monday-Friday: 8:00 AM-4:30 PM

Royal State National:
Supplemental Plan
Customer Service: (808) 539-1677
Toll-Free: (888) 942-2447
Claims: (808) 539-1621
Monday-Friday: 8:00 AM-4:30 PM

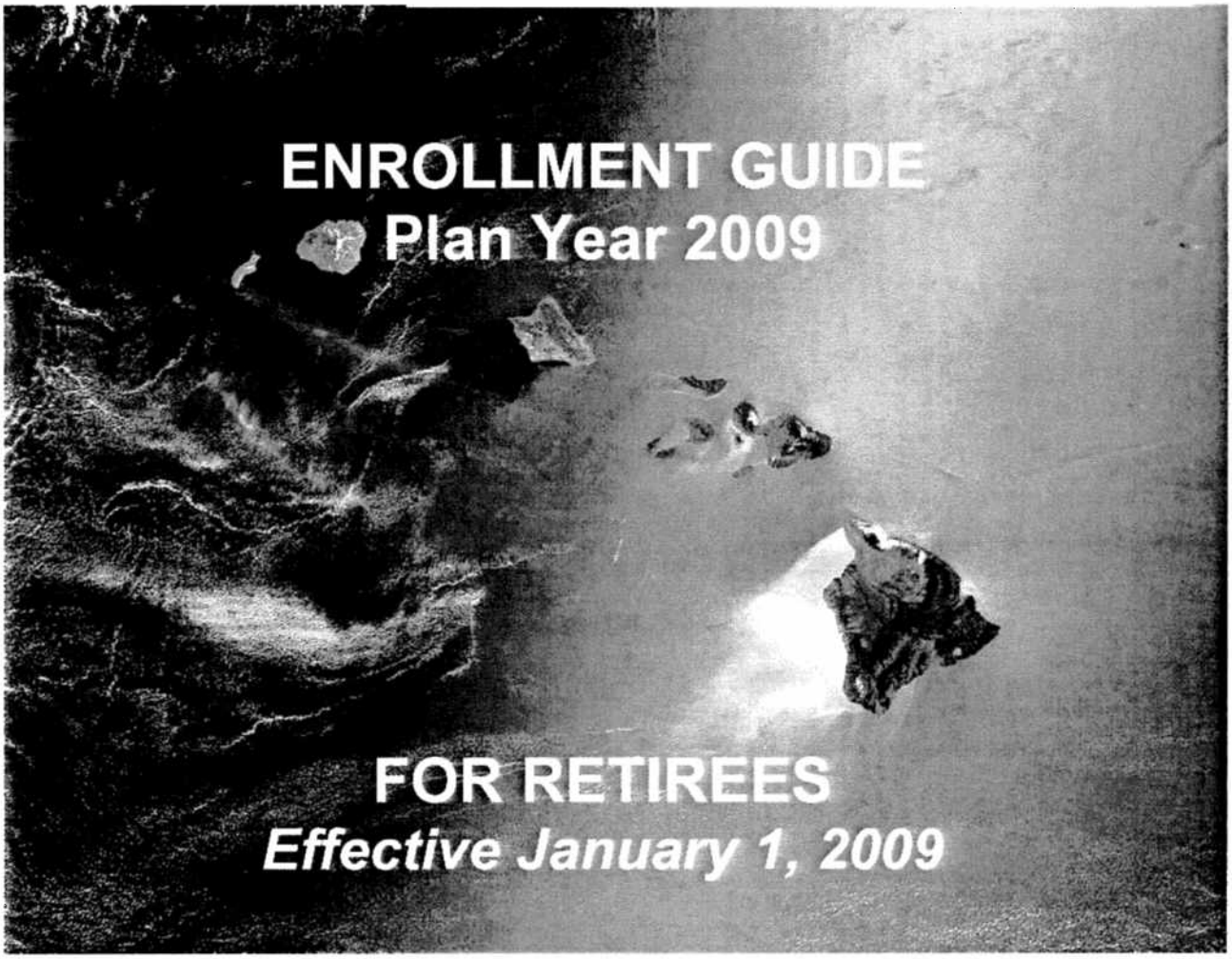
NMHC:
Toll-Free: (866) 533-6977
Available 24 hours a day

HDS:
Oahu: (808) 529-9310
Toll Free: (866) 702-3883
Monday-Friday: 7:30 AM-4:30 PM

VSP:
Oahu: (808) 532-1600
Toll Free: (800) 522-5162
Monday-Friday: 7:30 AM-4:30 PM
Toll Free for Mainland: (800) 877-7195
Monday-Friday: 5:00 AM-7:00 PM (PST)
Saturday: 6:00 AM-2:30 PM (PST)

Standard Insurance Company:
Toll Free: (888) 408-2298
Monday-Friday: 7:30 AM-4:30 PM

Hawaii
Employer-Union Health Benefits Trust Fund (EUTF)



Open Enrollment: October 14 through November 13, 2008
Election Form Deadline: November 20, 2008

TABLE OF CONTENTS

Attention: Medicare Eligible Members
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. The EUTF sponsored prescription drug plan offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. Your Notice of Creditable Coverage is on page 14. **If you enroll in another Part D plan, you will lose your Part D coverage through the EUTF.**

WELCOME!

This is your Open Enrollment Guide for the 2009 Plan Year. Please follow the instructions in this guide carefully. Take the time to review the plan options available to you. If you are making any changes, be sure to turn in your election form, EC-2, by **November 20th, 2008.**

Note: If you have made or submitted any changes a week or two prior to September 1, 2008, your changes may not be reflected on the benefit notice which lists your current benefit plan enrollments. You may contact the EUTF to verify any changes submitted after that date.

HIGHLIGHTS FOR PLAN YEAR 2009 (Jan. 1, 2009 through Dec. 31, 2009)

Plan	Carrier	Benefit Changes
Medical	HMA	No Change
	HMSA	Minor language clarifications and administrative changes eff. 7/1/08
	Kaiser	New: Silver & Fit Program Medicare Approved Hepatitis B drugs: $0 copay
Prescription Drug	NMHC	No Change
Dental	HDS	No Change
Vision	VSP	Services now based on Calendar Year
Life Insurance	Standard	No Change

You now have more flexibility on how you choose your benefits!!

1. **For yourself:** You have the option to choose either all the plan benefits or a la carte.
   Example: Medical, Drug, Vision and Dental Only
   Medical Only or Drug Only or Vision Only or Dental Only
   Or Any Combination
2. **For your dependents:** You have the option to choose the plan benefits for your dependents based upon your own selections or none at all. Your dependent(s) medical plan must be the same carrier as your plan Also, dependents may not enroll in a plan that you do not enroll in. (For example, if you do not enroll in a dental plan, your spouse may not enroll in a dental plan.)

Example:	You choose:	Your dependents can choose:
1	PPO *Med, Drug, Vision and Dental	Med or Drug or Vision or Dental or All or any combination or none
2.	PPO Med, Vision and Dental	Med or Drug or Vision or any combination or none
3.	PPO Drug and Dental	Drug or Dental or both or none

* Kaiser participants must take both medical and drug plans as a bundle.

OPEN ENROLLMENT INSTRUCTIONS

Step 1: Review the choices available to you and decide whether you want to change or keep your plans. Review the Plan Comparison Charts which summarize plan benefits beginning on page 12.

Step 2: If you have questions about your plan choices, please attend an Open Enrollment Benefit Fair.

During Open Enrollment, all retirees are invited to explore healthcare and insurance options at the Benefit Fairs. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMA HMSA Kaiser
Prescription Drug plan:	NMHC
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	Standard Insurance Company

Step 3: Review your Open Enrollment materials and the Summary of Benefits in this guide.

If you want more specific information regarding the different plans, please contact the applicable insurance carrier for your personal copy of their plan's Guide to Benefits. You can access the EUTF website, www.eutf.hawaii.gov for the latest information regarding the open enrollment.

You can add dependents, including spouse, children or a domestic partner (DP) to your plan during open enrollment. To add a DP to your plan, please contact the EUTF to obtain the documents required to enroll a DP or go to the EUTF website, www.eutf.hawaii.gov, to download the appropriate forms. Turn in the completed forms to the EUTF.

Remember, under EUTF rules, retirees are required to notify the EUTF of changes in dependent eligibility. Failure to do so may result in loss of premiums and additional benefit rights, such as COBRA, for dependents.

Step 4: **Make your selections on the EC-2 form and submit the completed and signed form to the EUTF no later than November 20, 2008.**

A: To make any changes to your personal information, simply complete the corrected information on the EC-2 form.

B: To make changes to your plan or coverage, make your selections on the EC-2, Enrollment Change form, and submit the completed and signed form to the EUTF.

C: To add a dependent, enter the appropriate information in the dependents section on the EC-2 form.

NOTE: You will notice that to protect your privacy your benefit notice does not include your social security number. The HB number is your EUTF ID number. You will need to provide this ID number when communicating with the EUTF. If you are adding a new dependent, you are required to submit your dependent's social security number at the initial enrollment.

IT IS ABSOLUTELY CRITICAL THAT YOU SUBMIT ANY CHANGES TO THE EUTF OFFICE NO LATER THAN November 20, 2008. Forms submitted after November 20, 2008 will be rejected.

Step 5: The EUTF will forward your enrollment confirmation notice by the end of December 2008. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. You may make corrections to your enrollment that you submitted on the EC-2 enrollment form. **NO CHANGES TO YOUR ORIGINAL SELECTIONS WILL BE ALLOWED AFTER November 20, 2008**, only corrections!

If you want to change your benefits or make other changes:

You must make changes during the open enrollment period if:

- You want to choose a different benefit plan
- You want to change coverage for dependents

You can add dependents, including spouse, children or a domestic partner (DP) to your plan during open enrollment. To add a DP to your plan, please contact the EUTF to obtain the documents required to enroll a DP or go to the EUTF website, www.eutf.hawaii.gov, to download the appropriate forms.

Remember, under EUTF rules, retirees are required to notify the EUTF of changes in dependent eligibility. Failure to do so may result in loss of premiums and additional benefit rights, such as COBRA, for dependents.

IMPORTANT: If any of your dependents are deleted due to a divorce, or becoming ineligible due to age or loss of student status, do not submit these deletions with your open enrollment changes. These should be reported when the event occurred (a qualifying event).

IMPORTANT: OPEN ENROLLMENT DATES

Open Enrollment is from October 14 through November 13, 2008.

Effective date for changes will be January 1, 2009. Each retiree is receiving this guide along with a benefit notice that contains the information that the EUTF had as of September 1, 2008. Each retiree is asked to review the information for accuracy and make any changes that are needed. You may cross out any information that should be deleted and legibly print any new information.

Schedule of Open Enrollment Benefit Fairs

Address locations are also provided on the website: www.hieutf.org

OCTOBER 2008			
Date	**Times***	**Facility**	**Location**
Oct 14	9:00am & 1:00pm	War Memorial Convention Ctr (Hall)	Lihue
Oct 14	9:00am & 1:00pm	Mauka Lani School Cafeteria	Kapolei
Oct 15	9:00am & 1:00pm	Windward Comm College (Akoakoa 103&105)	Windward
Oct 20	9:00am & 1:00pm	Kekuaokalani Gym	Kona
Oct 22	9:00am & 1:00pm	Aunt Sally's Luau Hale	Hilo
Oct 24	9:00am & 1:00pm	Ala Wai Community Center	Honolulu
Oct 27	9:00am & 1:00pm	Kokohead Community Center	Hawaii Kai
Oct 28	9:00am & 1:00pm	Maui Okinawan Cultural Center	Wailuku
Oct 30	10:30am	Mitchell Pauole Center	Molokai
Oct 31	9:00am & 1:00pm	Ala Wai Community Center	Honolulu

NOVEMBER 2008			
Nov 3	9:00am & 1:00pm	Kokohead Community Center	Hawaii Kai
Nov 5	9:00am & 1:00pm	Mission Memorial	Honolulu
Nov 6	9:00am & 1:00pm	Mission Memorial	Honolulu
Nov 7	10:30am	Waimea Civic Center	Waimea
Nov 10	9:00am & 1:00pm	War Memorial Convention Ctr (Hall)	Lihue
Nov 12	9:00am & 1:00pm	Aunt Sally's Luau Hale	Hilo
Nov 13	9:00am & 1:00pm	Maui Okinawan Cultural Center	Wailuku

*Each session will include a 45 minute presentation. In addition, insurance carrier respresentatives will be available during and after the presentations to answer your questions.

Benefit Fair Locations

HAWAII

Aunt Sally's Lu'au Hale
799 Piilani Street
Hilo, HI 96720

Waimea State Office Bldg Conference Room
67-5189 Kamamalu Street
Kamuela, HI 96743

Kekuaokalani Gym
75-5530 Kuakini Highway
Kailua-Kona, HI 96743

KAUAI

War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

MAUI

Maui Okinawa Cultural Center
688 Nukuwai Street
Wailuku, HI 96793

MOLOKAI

Mitchell Pauole Center
90 Inoa st
Kaunakakai, HI 96748

OAHU

Mauka Lani School
92-1300 Panana
Kapolei, HI

Mission Memorial Auditorium
550 S. King Street
Honolulu, HI 96813

Kokohead District Park
423 Kaumakani Street
Honolulu, HI 96825

Windward Community College
45-720 Keaahala Road
Kaneohe, HI 96744

Ala Wai Community Park
2015 Kapiolani Blvd.
Honolulu, HI 96826

CHOICES FOR PLAN YEAR 2009

Medical Health Plan Options See Page 12 for plan comparisons

Preferred Provider Organization Options: **EUTF PPO Medical (HMA)**
EUTF PPO Medical (HMSA)

A Preferred Provider Organization (PPO) is a medical plan that provides a higher benefit if you visit doctors that are part of the plan's network. If you decide to see a physician who is not a member of the plan's network, benefits will be at a reduced level. Most PPO plans, including the ones offered to you by the EUTF, require coinsurance or co-payments for services.

Health Maintenance Organization Options: **Kaiser Comprehensive, Prescription Drug**

A Health Maintenance Organization (HMO) is a medical plan that allows you to visit doctors only within a specific network. HMOs usually charge a minimal co-payment for services.

Plan Changes (Effective January 1, 2009) For Medicare Retirees:

- New fitness benefit: Silver & Fit
  - Gym membership at contracted gyms (no separate gym membership fee)
  - Gym membership will include exercise classes designed for seniors
  - Home exercise kit (with quarterly exercise DVDs) for members who reject gym membership
  - Exercise support knowledge tools (i.e., online exercise and fitness tips, fitness newsletter)
  - Community-based fitness support events (i.e., nutrition class at community center).

- Change in drug copay: Hepatitis B covered under Medicare Part B
  - 2008 benefit resulted in $10 drug copay for each hepatitis B injection if drug met Medicare criteria for Part B coverage.
  - 2009 benefit will be $0 drug copay for each hepatitis B injection if drug meets Medicare criteria for Part B coverage

Coverage on Molokai and Lanai: Effective July 1, 2008, Kaiser Permanente has clinicians based on the islands of Molokai and Lanai. Please contact Kaiser's Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) for more information.

Important Information for Out-of-State Retirees Enrolled in Kaiser medical plan

Act 167, 2006 SLH changed the contribution method for health insurance premiums for retirees outside of Hawaii. Effective July 1, 2007, the EUTF stopped offering group coverage for Kaiser Permanente on the mainland. However, you may enroll in the Kaiser Permanente medical plan of your choice, subject to exceptions as noted below. You will be reimbursed for the premiums paid for a personal health insurance policy with Kaiser Permanente. The reimbursement shall be the lesser of:

(1) The actual cost of the personal health insurance policy; or

(2) The amount of the state or county contribution for the most comparable health benefits plan.

Reimbursements shall be paid by the fund on a quarterly basis upon the presentation of documentation that the premiums for the personal health insurance policy have been paid by the employee-beneficiary.

Each Kaiser region has individual conversion options for members to continue individual membership. Conversion options ensure continuous coverage with no break in coverage and no medical screening. Rates and benefits vary by region.

If you are Medicare eligible, you must enroll in Kaiser's Senior Advantage plan. You will be required to complete a Kaiser Permanente Senior Advantage enrollment form. Otherwise, you will not be eligible for coverage under Medicare rules.

There are many different options with a range of premiums and coverage. If you are enrolled in a Kaiser Permanente plan and would like to continue membership, please contact the Kaiser Customer Service office in your region to obtain information and complete any necessary paperwork.

During open enrollment, if you decide not to enroll in a Kaiser Permanente plan, you also can enroll in the EUTF's Preferred Provider Organization, administered by either HMA or HMSA. See page 12 of this guide for more information about the PPO.

Prescription Drug Plan: **EUTF Prescription Drug Plan (NMHC)**

The EUTF's prescription drug plan is administered by National Medical Health Card (NMHC). This plan is the prescription drug coverage for the PPO options, administered by HMA and HMSA, for the supplemental medical plan administered by HMSA, and for stand-alone drug coverage.

Dental: **Hawaii Dental Service (HDS)**

Flossing, brushing and regular visits to a dentist for checkups are critical components of every oral health program. These simple measures help prevent tooth decay and detect other oral health problems early to avoid the need for emergency dental care in the future. A dentist can also help detect diseases such as diabetes and other health conditions by examining your teeth and gums.

Your plan provides:

- 100% coverage for diagnostic and preventive services
- 60% coverage for basic services such as fillings, root canals and oral surgery
- 60% coverage on all major work such as crowns, bridges and dentures
- The plan maximum is $1,000 beginning July 1st and will continue to refresh every July 1st.

HDS recently updated its public Web site with a fresh, new look that now includes a section exclusively for EUTF members. EUTF participant can access this page through the EUTF Web site or by visiting the HDS Web site directly. This section includes a copy of the retiree dental benefits brochure. Participants can also check on their eligibility, view information on past services, find a participating dentist in Hawaii or on the Mainland, and view oral health and wellness information. We invite you to visit our Web site at www.deltadentalhi.org. You may also reach us by calling the exclusive EUTF Customer Service Member Line at 529-9310 or toll-free at 866-702-3883.

Vision: **Vision Service Plan (VSP)**

Your Coverage from a VSP Doctor

Exam covered in full every calendar year, after a $10 Copay

Prescription Glasses

Lenses covered in full every calendar year, after a $25 Copay

Frame every other calendar year

- Up to $120, plus 20% off any out-of-pocket costs

~OR~

Contact Lenses every calendar year

- $120 allowance

Extra Discounts and Savings available

- Glasses and Sunglasses
- Contacts
- Laser Vision Correction

Dollar for dollar, you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You will also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call VSP first at 800-877-7195.

Life Insurance: **Standard Insurance Company**

Your life insurance benefit remains at $2,372. Since this benefit is only for beneficiaries and the coverage is the same for everyone, you do not need to make an election for this coverage.

In addition, your life insurance includes the following added benefits:

- Repatriation of remains benefit. This benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.
- MEDEX® Travel Assist program. This benefit is designed to help you and eligible family members respond to medical care situations, and many other emergencies, when you are traveling for business or pleasure 100 miles or more away from home.

Below are some key features of the MEDEX program that you should be aware of:

- All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.
- MEDEX does not cover traveling for the purpose of obtaining medical services or treatment.
- International travel is only covered for up to 90 days for any one trip.
- When calling MEDEX, please reference Group #9061. The policy holder is Standard Insurance Company.

Please see the MEDEX Travel Assist insert located on the page 25 for more details about the services available, plan restrictions, as well as your identification card. Your identification card contains the phone numbers and email address you'll need to contact MEDEX, so keep it with you when you travel.

SUMMARY OF BENEFITS

THIS COMPARISON IS ONLY A SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN. Benefits will be administered as described in each plan's documents. For further information contact the carrier or administrator.			
Plan Provisions	**PPO In-Network (HMA & HMSA)**	**PPO Out-of-Network (HMA & HMSA)**	**Kaiser HMO**
General			
Deductible Single/Family	$100/$300	$100/$300	None/None
Out-of-pocket limit Single/Family	$2,500/ $7,500	$2,500/ $7,500	$1,500
Lifetime Benefit Maximum	None	None	None
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Routine physical exams	Not Covered	Not Covered	$15
Mammography	20%*	30%*	$15
Second opinion – surgery	10%*	30%	No Charge
Emergency Room (ER care)	10%*	10%*	$25
Ambulance	20%	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician services	10%*	30%	No Charge
Surgery	10%*	30%	No Charge
Anesthesia	10%*	30%	No Charge
Chemotherapy	20%	30%	$15
Radiation Therapy	20%*	30%	
Surgery	10%* (Cutting)	30%	$15
Outpatient Services			
Allergy Testing	20%	30%	$15
Other Diag. Lab, X-ray & Psych Testing	20%*	30%	$15
Anesthesia	10%*	30%	No Charge
Mental Services			
Inpatient care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15

[1] Except for Nutritional Counseling.
* Deductible does not apply.

Plan Provisions	PPO In-Network (HMA & HMSA)	PPO Out-of-Network (HMA & HMSA)	Kaiser HMO
Other Services			
Durable Medical Equipment	20%	30%	20%, some exclusions
Home Health care	No Charge	30%	No Charge
Hospice Care	No Charge	Not Covered	No Charge
Nursing facility - skilled care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per year
Physical & Occupational Therapy	20%	30%	$15
Prescription Drugs	**NMHC**	**NMHC**	**Kaiser**
Generic (1st Level)	$5 co-pay	$5 co-pay + 20%	$15 co-pay
Preferred Brand (2nd Level)	$15 co-pay	$15 co-pay + 20%	$15 co-pay
Other Brand (3rd Level)	$30 co-pay	$30 co-pay + 20%	$15 co-pay
90-day mail order	$10 Generic $35 Preferred; Brand $60 Other Brand	Not Covered	$30 co-pay

If You or One of Your Dependents Are Eligible for Medicare

Notice of Creditable Coverage

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan other than a supplemental plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

Notice of Creditable Coverage

Important Notice of Creditable Coverage from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the EUTF and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The EUTF has determined that the prescription drug coverage offered by National Medical Health Card (NMHC) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing prescription drug coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. A beneficiary leaving the EUTF coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current medical coverage with the EUTF pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the EUTF and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage, contact our office for further information at (808) 586-7390 or toll free at 1-800-295-0089.

NOTE: You will receive this notice annually and at other times in the future, such as, before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the EUTF changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you later enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: 10/1/08

Name of Entity/Sender: Hawaii Employer-Union Health Benefits Trust Fund

Contact--Position/Office: Customer Service

Address: 201 Merchant Street, Suite 1520, Honolulu HI 96813

Phone Number: 808-586-7390

What to Do If You Have Non-Creditable Coverage:

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. A beneficiary leaving the EUTF's coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

This may mean that you will have to wait to enroll in Medicare prescription drug coverage and that you may pay a higher premium (a penalty) if you join later and you will pay that higher premium as long as you have Medicare prescription drug coverage.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your premium will go up at least 1% per month for every month after May 15, 2006, that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without prescription drug coverage that's at least as good as Medicare's, your premium will always be at least 19% higher than what many other people pay.

Your current medical coverage with the EUTF pays for other health expenses in addition to prescription drug expenses. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health benefits through EUTF's supplemental plans.

If you drop your current prescription drug coverage through the EUTF and enroll in Medicare prescription drug coverage through another plan, you may enroll back into an EUTF plan during the next open enrollment period.

When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. For more information, contact us at (808) 586-7390 or toll free 1-800-295-0089.

NOTE: You will receive this notice annually and at other times in the future, such as before the next Medicare prescription drug coverage open enrollment period, and if the EUTF's supplemental plans change. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 10/1/08

Name of Entity/Sender: EUTF

Contact--Position/Office: Customer Service

Address: 201 Merchant Street, Suite 1520, Honolulu HI 96813

Phone Number: 808-586-7390

EUTF Medicare Part B Plan

WHO: Applies to all retirees and their spouses who are eligible to enroll in Medicare Part B. Spouses who are still working but enrolled in an EUTF retiree medical plan are required to enroll in Part B.

WHAT: Medicare Part B reimbursements are dependent on you submitting a copy of your Medicare Part B card to the EUTF. **Your reimbursement will begin the later of the date on your card or the 1st day of the month in which the EUTF receives a copy of your card, no earlier.**

WHEN: When you become eligible for Medicare, **you must enroll in Medicare Part B** to continue your retiree health benefits through the EUTF. The EUTF will reimburse you quarterly by direct deposit to your financial institution account for the cost of the Medicare Part B premium. These payments do not include reimbursements for any penalty premium payments charged by Medicare.

WHERE: If you have access to the internet, go to our website at www.eutf.hawaii.gov for more information and the appropriate forms. Or you can contact the EUTF at 808-586-7390 or toll free 800-295-0089 and request that the instructions and forms be sent to you. You also can visit the EUTF at Suite 1520, 201 Merchant Street, Honolulu HI 96813.

WHY: Act 136, SLH 1999, **requires all eligible state and county retirees and their spouses to enroll in Medicare Part B** if they are enrolled in a EUTF retiree medical plan. This statute is incorporated in Chapter 87A, HRS, paragraph 87-23(4).

HOW: Forward a copy of your Medicare Part B card to the EUTF via mail or fax. You need to submit proof of your enrollment in the Medicare Part B plan if you want to continue coverage under the retiree plan.
Although the EUTF may send reminder letters, you ultimately are responsible to submit the proper documentation.

FREQUENTLY ASKED QUESTIONS:
Why am I required to enroll in Medicare Part B when I am eligible?
The requirement for all State and County retirees and dependents to enroll in Medicare Part B was established by Act 252, 2001 SLH. This act was incorporated in Chapter 87A, Hawaii Revised Statutes in the following paragraph.

> Paragraph 87A-23(4) All employee-beneficiaries or dependent-beneficiaries who are eligible to enroll in the Medicare Part B medical insurance plan shall enroll in that plan as a condition of receiving contributions and participating in benefits plans under this chapter. This paragraph shall apply to retired employees, their spouses, and the surviving spouses of deceased retirees and employees killed in the performance of duty;

The law also allowed the board to allow those not enrolled in Medicare Part B to continue with the EUTF, such as retirees that attained age 65 prior to the enactment of the law that required eligible Medicare participants to enroll in Medicare Part B. In addition, by Medicare law, retirees

whose residence is outside of the United States are ineligible to be enrolled in Medicare. These retirees and dependents are also exempt from this requirement.

> **Paragraph 87A-23(5)** The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the Medicare Part B medical insurance plan, may participate in the plans offered by the fund.

How and when will I be reimbursed for my Medicare Part B premiums

Under current law, the amount of your Medicare Part B reimbursement is based on the Medicare premium rate that is published by Medicare in the early part of November each year. If you became eligible for Part B reimbursements prior to July 1, 2006, your payments will either be by check or by electronic means. On April 27, 2006, the Governor signed Act 39, 2006 SLH, that requires all individuals who become eligible to receive Part B reimbursements on or after July 1, 2006 to accept direct deposit of the reimbursements. Generally, your reimbursement checks will be sent or deposited the first week of April, July, October and January for the prior quarter

Who is eligible for Medicare Part B reimbursements?

You are eligible for Medicare Part B reimbursements if: (a) you are a retiree or spouse of a retiree who is eligible to enroll in the EUTF retiree plans; (b) you are enrolled in Medicare Part B; and (c) you have submitted proof to the EUTF of your enrollment in Medicare Part B. To show proof of your enrollment in Medicare Part B, you must send the EUTF a copy of your Medicare card. If you have kept the EUTF informed of your current address, the EUTF normally will send you a notice to enroll in Medicare Part B approximately two months prior to your 65th birthday month. Submit that notice with a copy of your Medicare card to the EUTF.

IMPORTANT: REIMBURSEMENT COMPUTATION IS BASED ON THE DATE OF YOUR CARD OR THE FIRST DAY OF THE MONTH IN WHICH THE EUTF RECEIVES A COPY OF YOUR CARD.

The EUTF will reimburse the full amount of the premium less any penalties.

Who is eligible for Medicare?

Generally, Medicare is available for people age 65 or older, younger people with certain disabilities, and people with end stage renal disease (permanent kidney failure requiring dialysis or transplant).

You are eligible for premium-free Medicare Part A if you are age 65 or older and you worked and paid Medicare taxes for at least 10 years. If you did not pay Medicare taxes while you worked, and you are age 65 or older and a citizen or permanent resident of the United States, you may still be able to buy Medicare Part A coverage.

While most people do not have to pay a premium for Medicare Part A, everyone must pay for Medicare Part B if they want it. The monthly premium normally is deducted from your social security, railroad retirement, or civil service retirement check. If you do not get any of these payments, Medicare sends you a bill for your Part B premiums.

If you have questions about your eligibility for Medicare Part A or Part B, or if you want to apply for Medicare, call the Social Security Administration or visit their website at www.ssa.gov . The toll-free telephone number is: 1-800-772-1213. The TTY-TDD number for the hearing impaired is 1-800-325-0778. You can also get information about buying Medicare Part A as well as Part B.

Who is required to enroll in Medicare Part B?

Any retiree, spouse or domestic partner, who reaches age 65 and qualifies for Medicare Part B, is required to enroll in Medicare Part B. There are situations where a spouse is still working and covered by an employer's group health insurance but is still required to enroll in Medicare Part B upon reaching age 65. Examples:

1. Retiree is age 60 and spouse is 65 years old and not working and both are covered under the EUTF retiree plan. Spouse is required to enroll in Part B. Reimbursement for spouse's Part B premium is sent to the retiree.
2. Retiree is 65 plus and spouse is 62 years old and receiving social security payments and both are covered under the EUTF retiree plan. Retiree is required to enroll in Part B but spouse is not required to enroll even though spouse receives social security payments. Reimbursement sent for retiree.
3. Retiree is 65 plus and not working, spouse is 67 and still actively working and both are covered under the EUTF retiree plan. Both retiree and spouse are required to enroll in Part B. Even if spouse has medical coverage through the spouse's employer, the spouse is still required to enroll in Part B to be eligible for coverage through the retiree plan. Reimbursement for both the retiree and spouse is sent to the retiree.
4. Retiree is 65 plus and enrolled in Medicare B, spouse is still working. Both are covered under the spouse's non-EUTF employer group health plan and the retiree is not enrolled in the EUTF health benefits plan. For EUTF purposes, the retiree is not required to be enrolled in Part B. Since the retiree is enrolled in the spouse's non-EUTF employer group health plan, there is no Medicare Part B reimbursement. Medicare also does not require the retiree to enroll in Medicare Part B when covered by an employer group health plan.
5. Retiree is 65 and spouse is not working for the State or County and chooses to provide family health benefits through the active employee's EUTF plan. Retiree is not required to enroll in Part B as long as the retiree is covered by the spouse's employer health plan and also will not be eligible for Medicare reimbursement if enrolled in Part B.

Table illustrates the above situations:

Examples	Retiree		Spouse		**Must enroll in Medicare Part B**	
	Age	Working?	Age	Working?	**Retiree**	**Spouse**
#1 – Both are covered under the EUTF Retiree Plan; both are not working	60	No	65	No	**No**	**Yes (Reimbursement sent to Retiree)**
#2 – Both are covered under the EUTF Retiree Plan; Spouse receiving Social Security pymts	65+	No	62+	No	**Yes**	**No**
#3 – Both are covered under the EUTF Retiree Plan; both are working	65+	No	67	Yes	**Yes**	**Yes (Reimbursement sent to Retiree)**
#4 – Both are covered under the spouse's non-EUTF Medical Plan; both are working	65+	Yes	65+	Yes	**No (Also, no reimbursement if Retiree decides to enroll in Part B)**	**No (Also, no reimbursement if Retiree decides to enroll in Part B)**
#5 – Both are covered under the spouse's EUTF Active Plan electing Family coverage; both are not working for State or County	65+	Yes	65+	Yes	**No (Also, no reimbursement if Retiree decides to enroll in Part B)**	**No (Also, no reimbursement if Retiree decides to enroll in Part B)**

Should I sign up for Medicare Part B if I or my spouse are still working and are covered by an employer group health insurance?
You may want to wait to sign up for Part B if you or your spouse has health coverage through an employer.

What will happen if my spouse or I fail to enroll in Medicare Part B when eligible?
EUTF Administrative Rule 5.04 states "when the retiree fails to enroll in Medicare Part B, the enrollment for the retiree and family will be cancelled from all benefit plans offered or sponsored by the EUTF." If the spouse fails to enroll, then only the spouse will be cancelled from all benefit plans offered by the EUTF. If your spouse wants to continue coverage under your retiree plan, your spouse is required to enroll in Medicare Part B even though he/she is still working. Enrollment in Medicare Part B is required to be eligible for coverage under the EUTF retiree plans.

I didn't apply for Medicare when I turned 65 even though I did not have health coverage from my job or through my spouse's employer. What should I do?
If you missed initial enrollment (a seven-month period starting three months before your 65th birthday and ending three months after your birth month), you must wait to apply for Medicare until the general enrollment period during January and March of each year. Your coverage will start the following July. You must apply at your local social security office. You will pay a 10 percent Part B premium penalty for each year you delayed signing up. Your EUTF Medicare Part B reimbursements will not include payment for any penalty amounts.

Can I my delay Medicare Part B enrollment without paying higher premiums?
Yes. In certain cases, you can delay your Medicare Part B enrollment without having to pay penalty premiums. For example, if you didn't take Medicare Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer, you can sign up for Medicare Part B during a special enrollment period. However, if your spouse is covered under your EUTF retiree plan, your spouse must enroll in Medicare Part B to be covered.

EUTF Medicare Part D Plan

In 2007, the EUTF elected to enroll all Medicare-eligible participants into the EUTF's Medicare Part D Prescription Drug benefit plan.

What this means to you is, if you are a Medicare-eligible participant, **you do not need to leave the EUTF plan and enroll in another Medicare Part D plan to obtain prescription drug benefits.** The open enrollment period for all EUTF retirees is from October 14 through November 13, 2008.

The open-enrollment period for all non-EUTF Medicare Part D plans is coming soon: November 15 - December 31, 2008. You will probably start receiving advertisements from other plans during this time. Please know that if you are happy with your coverage under the EUTF Part D plan, you do not have to take any action. Medicare only allows you to enroll in one Medicare Part D plan. Therefore, if you enroll in a non-EUTF Part D plan, you will be terminated from the EUTF's Part D plan.

If you do not want to enroll in a non-EUTF Part D plan, do nothing. You will automatically stay in the EUTF Medicare Part D plan.

Frequently Asked Questions and Answers:

Why will I receive communications and marketing materials for other Part D drug plans?

CMS allows all Part D plans to reach out to Medicare participants, beginning Nov 15 of each year. Other Part D plans may contact you to encourage enrollment in their plan during this time, thereby leaving (i.e., disenrolling from) the EUTF's Medicare Prescription Drug plan.

What happens if I do chose to enroll in another Part D drug plan?

If you do decide to enroll in a non-EUTF Part D plan between November 15 and December 31, you will be disenrolled from the EUTF Medicare Part D plan because Medicare allows you to enroll in only one Part D plan.

Is the EUTF Medicare plan as good as other Medicare Part D plans?

All Part D plans must offer a minimum coverage to meet the Medicare Standard Part D plan requirements. The EUTF Medicare Part D plan exceeds this minimum and offers participants richer, more generous, coverage than the Medicare Standard Part D plan. The chart on page 24 describes your benefits under the EUTF Medicare plan and a comparison to other plans.

What must I do if I choose to enroll in a non-EUTF Part D plan?
Please notify the EUTF in writing that you have enrolled in another Part D plan.

What if I have the Kaiser Permanente Senior Advantage medical plan?
All Medicare eligible members are enrolled in the Medicare Part D plan through Kaiser Senior Advantage. The EUTF enhances the Medicare Part D coverage with supplemental drug benefits that makes your current prescription drugs coverage better than the standard Medicare Part D plan. There is no additional cost for the Medicare Part D premiums.

Is there any control over how drug plans choose prescription drugs for their formulary?
CMS requires two drugs in every therapeutic category and class. The prescription drug plans have two options for their classification system. They may present their own for CMS review, or they may use the model guidelines recently published by U.S. Pharmacopeia (USP). In either case, CMS thoroughly evaluates the submitted formulary design to ensure that it contains adequate access to medically necessary drugs and does not discriminate against any groups of beneficiaries.

What happens to my EUTF coverage if I choose to enroll in a non-EUTF Part D plan?
You will lose your prescription drug coverage through the EUTF for yourself and all dependents. This means that if your spouse is not eligible for Medicare, your spouse may not have any prescription drug coverage. You may continue medical coverage through the PPO.

If I enroll in a non-EUTF Part D plan, will I be reimbursed for my Medicare Part D premiums?
No.

What happens to my spouse's EUTF coverage if my spouse chooses to enroll in a non-EUTF Part D plan?
If you are enrolled in the EUTF prescription drugs plan and your spouse opts out of the plan, your spouse will be disenrolled from the EUTF Part D plan.

I have been overwhelmed by the many Medicare Part D plans that tell me their coverage is better than other plans. How does the EUTF Part D plan compare to all other Medicare plans offered by various commercial enterprises?
Overall, there are no existing Part D plans that provide better coverage than the EUTF's. The Part D plan formulary is part of the overall formulary offered through the EUTF. There are prescription drugs that may not be included under Part D but are covered under the EUTF plan. Most important, you do not have to pay for the Part D premiums and are not subject to losing benefits through the EUTF for yourself and for your family.

I have multiple medical and prescription drugs coverage through different employers. Why can't I choose how my prescription drugs are processed?
Unfortunately, when you have multiple retiree plans, each of the plans have its own rules. For example, if you opt out of a plan, you may lose all benefits forever from that employer. Or, as with TRICARE, you cannot use its mail order program if you have another coverage. These rules are established independently of each other and do not necessarily work in concert with each other. You will have to make the best choice for yourself, knowing that you may lose benefits for the other plans.

I am enrolled in the Kaiser medical plan. What will happen if I enroll in a Medicare Part D plan other than Kaiser?

If you enroll in Medicare Part D with another carrier, you will be automatically terminated from the Kaiser medical plan and you will have the choice to either enroll in a PPO plan (HMSA or HMA) or not to enroll in any medical plan. The Medicare Part D prescription drugs plan is part of the Senior Advantage plan. You cannot have one without the other.

Table Comparison of EUTF's Prescription Drug Plan vs. a standard Medicare Part D Plan

PLAN FEATURE	EUTF MEDICARE PART D PLAN			
ANNUAL DEDUCTIBLE:	$0			
COPAYMENTS FOR PAR PROVIDERS:	GENERIC	PREFERRED	NON-PREFERRED	TIER 4 (INJECTABLES) AND TIER 5 (SPECIALTY)
RETAIL 30 DAYS	$5	$15	$30	20%
RETAIL 90 DAYS	$15	$45	$90	20%
MAIL ORDER 90 DAYS	$10	$35	$60	20%
***MAXIMUM ANNUAL OUT-OF-POCKET:**	AFTER A PERSON SPENDS $4,050 FOR THE YEAR, EXPECTED CO-PAYMENTS WILL VARY. PLEASE REFER TO THE EVIDENCE OF COVERAGE.			

PLAN FEATURE	STANDARD CMS APPROVED MEDICARE PART D PLAN	
ANNUAL DEDUCTIBLE:	$275	
	COST OF COVERED DRUGS	
CO-INSURANCE*:	YOU PAY:	MEDICARE PAYS:
UP TO $275	***100%***	0%
FROM $276 TO $2,510	***25%***	75%
FROM $2,511 TO $4,050	***100%***	0%
OVER $4,050	***5%***	95%
***MAXIMUM ANNUAL OUT-OF-POCKET:**	AFTER A PERSON HAS SPENT $4,050 IN ELIGIBLE OUT-OF-POCKET DRUG COSTS IN A YEAR, MEDICARE PAYS 95% OF THE DRUG COSTS FOR THE REMAINDER OF THE YEAR	

***For 2009, the maximum annual out-of-pocket is $4,350.**

EUTF Contact Information

Mailing Address:
P.O. Box 2121
Honolulu, HI 96805

Location Address:
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, Hawaii

Local number: 808-586-7390
Toll-Free number: 800-295-0089
Fax number: 808-586-2161

Email address: eutf@hawaii.gov
Website address: www.eutf.hawaii.gov

NEED MORE INFORMATION?

HMA:
Oahu: (808) 951-4694
Toll Free: (866) 331-5913
Monday-Friday: 7:30 AM-5:00 PM

HMSA:
Oahu: (808) 948-6499
Hilo, Hawaii: (808) 935-5441
Kailua-Kona, Hawaii: (808) 329-5291
Kahului, Maui: (808) 871-6295
Lihue, Kauai: (808) 245-3393
Toll Free: (800) 776-4672
Monday-Friday: 8:00 AM-4:00 PM

Kaiser:
Oahu: (808) 432-5955
Toll Free: (800) 966-5955
Monday-Friday: 8:00 AM-5:00 PM
Saturday: 8:00 AM-12:00 PM

NMHC:
Toll-Free: (866) 533-6977
Available 24 hours a day

HDS:
Oahu: (808) 529-9310
Toll Free: (866) 702-3883
Monday-Friday: 7:30 AM-4:30 PM

VSP:
Oahu: (808) 532-1600
Toll Free: (800) 522-5162
Monday-Friday: 7:30 AM-4:30 PM
Toll Free for Mainland: (800) 877-7195
Monday-Friday: 5:00 AM-7:00 PM (PST)
Saturday: 6:00 AM-2:30 PM (PST)

Standard Insurance Company:
Toll Free: (888) 408-2298
Monday-Friday: 7:30 AM-4:30 PM

MEDEX® Travel Assist

Security That Travels With You

MEDEX

MEDEX® Travel Assist is a comprehensive program of information, referral, assistance, transportation and evacuation services designed to help you respond to medical care situations and many other emergencies that may arise during travel.

You do not need to enroll. As a participant in the Hawaii Employer-Union Health Benefits Trust Fund Group Life Insurance Policy issued by Standard Insurance Company, you are automatically covered.

MEDEX Provides the Following Services

- Pre-Trip Assistance including consulate and embassy locations, currency exchange information, health hazards advice and inoculation requirements, passport and visa information, weather information and travel locator services.
- Medical Assistance Services including locating medical care, case communications, translation and interpreter services, hotel convalescences arrangements, medical insurance assistance and prescription drug assistance.
- Emergency Transportation Services including emergency evacuations for medical treatment, medically necessary repatriation, repatriation of remains, family or friend travel arrangements, return of dependent children and vehicle return.
- Travel Assistance Services including emergency credit card and ticket replacement, emergency passport and document replacement, emergency cash and payment assistance, emergency message service, missing baggage assistance, locating legal services and bail bond services.
- Personal Security Services including real-time security intelligence and security evacuation services.

What MEDEX Travel Assist Does Not Cover

While MEDEX assists with most emergencies you may have away from home, it does not cover costs or expenses incurred because of:

- Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power
- Traveling against the advice of a physician
- Traveling for the purpose of obtaining medical services or treatment
- The commission of, or attempt to commit, an unlawful act
- Injury or illness caused by or contributed to by use of drugs or intoxicants, unless prescribed by a physician
- Psychiatric, psychological or emotional disorders, unless hospitalized
- Pregnancy and childbirth, except for complications of pregnancy
- Participation as a professional in athletics
- Expenses incurred for emergency evacuation or repatriation services as a result of injury or sickness while traveling within 100 miles of your place of residence
- Traveling outside your home country for more than 90 days for any one trip

How to Access Services

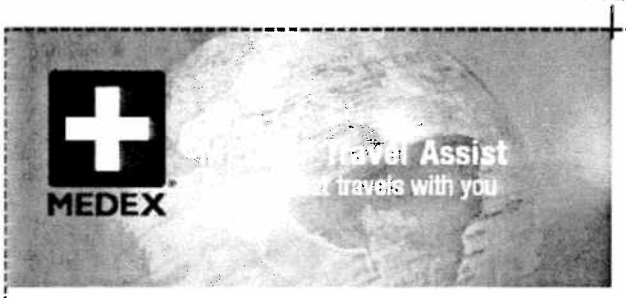
Simply cut out and sign the identification card below and keep it with you when you travel.

For additional information please visit **www.standard.com/mybenefits/hawaiiutf.**

All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.

The MEDEX Travel Assist program is available to participants in the Hawaii Employer-Union Health Benefits Trust Fund Group Life Insurance Policy issued by Standard Insurance Company. The program is subject to the terms and conditions, including exclusions and limitations, of the Employer Emergency Medical Assistance Service Certificate issued to participating policyholders by MEDEX Assistance Corporation, which is not affiliated in any way with Standard Insurance Company.

FOLD



Group #9061

NAME

The participant named is eligible for MEDEX® Travel Assist when traveling at least 100 miles from home or in a foreign country.

In the United States, Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda call toll-free 800-527-0218

In other locations worldwide, call collect 410-453-6330

MEDEX Travel Assist can also be reached at *operations@medexassist.com*.

MEDEX Travel Assist is not responsible for the availability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by MEDEX and for the expenses associated with them. All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.

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NOTES

Appendix N
Proposed Plan Benefit Designs

BENEFIT SUMMARY/COMPARISON

This summary/comparison is intended to provide a condensed explanation of plan benefits.
Certain limitations, restrictions and exclusions may apply.

3/10/09

Plan Design #	562 Active Plan Design #1		345 Active Plan Design #2		633 Active Plan Design #3		644 Active Plan Design #4		621 Active Plan Design #5		563 Retiree Plan Design #1	
Lifetime Maximum	Unlimited		$1,000,000 / $10,000 annual renewal		Unlimited		$2,000,000 / $10,000 annual renewal		$1,000,000 / $10,000 annual renewal		Unlimited	
Annual Deductible	$100 per person / $300 per family		$100 per person / $300 per family		None		$1,500 single / $3,000 per family		None		$100 per person / $300 per family	
Hospital Deductible	None		None		None		None		None		None	
Annual Copayment Maximum	$2,000 per person / $6,000 per family		$2,500 per person / $7,500 per family		$2,500 per person / $7,500 per family		$4,000 single / $8,000 per family		$10,000 per person		$2,500 per person / $7,500 per family	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Hospital and Facility Services												
Ambulatory Surgical Center (ASC)	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Emergency Room	90%	90%	90%	90%	All but $100 per visit	All but $100 per visit	90% after deductible	90% after deductible	50%	50%	90%	90%
Hospital Ancillary Services	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Hospital Room and Board	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Intensive Care Unit/Coronary Care Unit	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Intermediate Care Unit	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Isolation Care Unit	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Skilled Nursing Facility	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Physician Services												
Anesthesia	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Consultation Services	90%	70% after deductible	90%	70% after deductible	All but $20	All but $20	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Immunizations (standard)	100%	100%	100%	70% after deductible	100%	100%	100%	100%	50%	50%	100%	100% after deductible
Immunizations (Hepatitis-B)	100%	100%	100%[1]	70% after deductible[1]	100%	100%	100%	100%	50%[1]	50%[1]	100%[1]	100% after deductible[1]
Physician Visits	90%	70% after deductible	90%	70% after deductible	Office - All but $14 per visit Hospital - All but $20 per visit	Office - All but $14 per visit Hospital - All but $20 per visit	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Physician Visits - Emergency Room	90%	90%	90%	90%	All but $20 per visit	All but $20 per visit	90% after deductible	90% after deductible	50%	50%	90%	90%
Surgical Services												
Assistant Surgeon Services	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Cutting Surgery	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Non-cutting Surgery	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Reconstructive Surgery	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Surgical Supplies	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Testing, Laboratory and Radiology												
Allergy Testing	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Allergy Treatment Materials	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Diagnostic Testing – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Diagnostic Testing – Outpatient	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Diagnostic Testing within 48 Hours of Injury – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Diagnostic Testing within 48 Hours of Injury – Outpatient	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Laboratory and Pathology – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Laboratory and Pathology – Outpatient	90%	70% after deductible	80%	70% after deductible	100%	100%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Laboratory and Pathology within 48 Hours of Injury – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Laboratory and Pathology within 48 Hours of Injury - Outpatient	90%	70% after deductible	80%	70% after deductible	100%	100%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Radiology – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Radiology – Outpatient	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Radiology within 48 Hours of Injury– Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Radiology within 48 Hours of Injury– Outpatient	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Tuberculin Test	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Chemotherapy and Radiation Therapy												
Chemotherapy	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Radiation Therapy - Inpatient (for malignancy)	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Radiation Therapy - Outpatient (for malignancy)	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Radiation Therapy - Inpatient (for non-malignancy)	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Radiation Therapy - Outpatient (for non-malignancy)	90%	70% after deductible	80%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Other Medical Services and Supplies												
Ambulance (air)	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Ambulance (ground)	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Blood and Blood Products	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Dentist, Services of	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Dialysis and Supplies	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Evaluations for Hearing Aids	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	80%	80%	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Growth Hormone Therapy	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Home IV Therapy	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Inhalation Therapy	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Injections	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Medical Equipment, Appliances, and Supplies	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Medical Foods	90%	80%	80%	80%	80%	80%	90% after deductible	80% after deductible	80%	80%	80%	80%
Nutritional Counseling	80% after deductible	80% after deductible	Not Covered	Not Covered	Not Covered	Not Covered	80% after deductible	80% after deductible	50%	50%	80% after deductible	80% after deductible
Prosthetics & Orthotics	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Rehabilitation Therapy												
Cardiac Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Physical and Occupational Therapy – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Physical and Occupational Therapy – Outpatient[2](visits)	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Speech Therapy – Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Speech Therapy – Outpatient	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Diabetic Drugs, Supplies and Insulin												
Diabetic Supplies (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible	100% after deductible	Not Covered	Not Covered	Not Covered	Not Covered
Diabetic Supplies (Other Brand Name)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $15 copayment	100% after deductible and $15 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Diabetic Drugs (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $5 copayment	80% after deductible and $5 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Diabetic Drugs (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $15 copayment	80% after deductible and $15 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Diabetic Drugs (Other Brand Name)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $30 copayment	80% after deductible and $30 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Insulin (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $5 copayment	80% after deductible and $5 copayment	Not Covered	Not Covered	Not Covered	Not Covered

BENEFIT SUMMARY/COMPARISON

This summary/comparison is intended to provide a condensed explanation of plan benefits.
Certain limitations, restrictions and exclusions may apply.

3/10/09

Plan Design #	Active Plan Design #1		Active Plan Design #2		Active Plan Design #3		Active Plan Design #4		Active Plan Design #5		Retiree Plan Design #1	
Lifetime Maximum	Unlimited		$1,000,000 / $10,000 annual renewal		Unlimited		$2,000,000 / $10,000 annual renewal		$1,000,000 / $10,000 annual renewal		Unlimited	
Annual Deductible	$100 per person / $300 per family		$100 per person / $300 per family		None		$1,500 single / $3,000 per family		None		$100 per person / $300 per family	
Hospital Deductible	None		None		None		None		None		None	
Annual Copayment Maximum	$2,000 per person / $6,000 per family		$2,500 per person / $7,500 per family		$2,500 per person / $7,500 per family		$4,000 single / $8,000 per family		$10,000 per person		$2,500 per person / $7,500 per family	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Insulin (Other Brand Name)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $15 copayment	80% after deductible and $15 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Diabetic Supplies (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Diabetic Drugs (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $35 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Diabetic Drugs (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $60 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Insulin (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $10 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Disease Management and Preventive Services												
Disease Management and Preventive Services Programs	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
RSVP Screenings	90%	70% after deductible	80%	70% after deductible	100%	100%	90%	70%	100%	50%	80%	70% after deductible
Health Appraisal Program – Laboratory Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Health Appraisal Program – Physical Exams	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
HealthPass Exam	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
HealthPass Referred Screenings	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Physical Examinations	100%	100%	Not Covered	Not Covered	Not Covered	Not Covered	100%	100%	Not Covered	Not Covered	Not Covered	Not Covered
Special Benefits for Children												
Newborn Circumcision	90%	70% after deductible	Not Covered	Not Covered	90%	90%	90% after deductible	70% after deductible	50%	50%	Not Covered	Not Covered
Well Child Care Immunizations	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Well Child Care Laboratory Tests	90%	70%	80%	70%	100%	100%	100%	70%	50%	50%	80%	70%
Well Child Care Physician Office Visits	100%	70%	90%	70%	100%	100%	100%	70%	100%	50%	100%	70%
Special Benefits for Men												
Erectile Dysfunction	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Prostate Specific Antigen Test (PSA)	90%	70% after deductible	80%	70% after deductible	100%	100%	100%	70%	100%	50%	80%	70% after deductible
Vasectomy	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Special Benefits for Women												
Chlamydia Screening	90%	70% after deductible	80%	70% after deductible	100%	100%	100%	70%	50%	50%	80%	70% after deductible
Complications of Pregnancy	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Diaphragms and Cervical Caps	Not Covered	Not Covered	100% after $10 copayment per device	100% after $10 copayment per device	All but $10 per device	All but $10 per device	100% after deductible and $10 copayment	100% after deductible and $12 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Implants	50%	50%	50%	50%	80%	80%	50% after deductible	50% after deductible	50%	50%	50%	50%
Contraceptive Injectables	50%	50%	50%	50%	80%	80%	50% after deductible	50% after deductible	50%	50%	50%	50%
Contraceptive IUD	50%	50%	50%	50%	80%	80%	50% after deductible	50% after deductible	50%	50%	50%	50%
Contraceptive Oral (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $5 copayment	80% after deductible and $5 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Oral (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $15 copayment	80% after deductible and $15 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Oral (Other Brand Name)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $30 copayment	80% after deductible and $30 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Other Methods (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $5 copayment	80% after deductible and $5 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Other Methods (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $15 copayment	80% after deductible and $15 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Other Methods (Other Brand Name)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $30 copayment	80% after deductible and $30 copayment	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Contraceptive Diaphragms/Cervical Caps	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Regular Mail Order Benefits	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Contraceptive Oral (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $10 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Contraceptive Oral (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $35 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Contraceptive - Other Contraceptive Methods (Generic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $10 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order Contraceptive - Other Contraceptive Methods (Preferred)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	100% after deductible and $35 copayment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mammography (screening)	90%	70%	80%	70%	100%	100%	100%	70%	100%	50%	80%	70%
Newborn Care	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Nurse Midwives	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Pap Smears (routine)	90%	70% after deductible	80%	70% after deductible	100%	100%	100%	70%	100%	50%	80%	70% after deductible
Pregnancy Termination	90%	70% after deductible	90%	70% after deductible	90%	90%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Total Maternity Care	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	90%	90%	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Tubal Ligation	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Well Woman Exam	90%	70% after deductible	90%	70% after deductible	100%	100%	100%	70%	100%	50%	90%	70% after deductible
Special Benefits for Member and Covered Spouse												
In Vitro Fertilization	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Special Benefits for Homebound, Terminal, or Long-term Care												
Home Health Care	100%	70% after deductible	100%	70% after deductible	80%	80%	100% after deductible	70% after deductible	50%	50%	100%	70% after deductible
Hospice Services	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Mental Health and Substance Abuse												
Mental Health Facility Services	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Mental Health Physician Services - Inpatient	90%	70% after deductible	90%	70% after deductible	All but $20 per visit	All but $20 per visit	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Psychological Testing - Inpatient	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Psychological Testing - Outpatient	90%	70% after deductible	80%	70% after deductible	90%	80%	90% after deductible	70% after deductible	50%	50%	80%	70% after deductible
Substance Abuse Facility Services	90%	70% after deductible	90%	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Substance Abuse Physician Services - Inpatient	90%	70% after deductible	90%	70% after deductible	All but $20 per visit	All but $20 per visit	90% after deductible	70% after deductible	50%	50%	90%	70% after deductible
Organ and Tissue Transplants												
Corneal Transplants	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Kidney Transplants	90%	70% after deductible	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	90% after deductible	70% after deductible	50%	50%	Regular Plan Benefits	Regular Plan Benefits
Organ Donor Services	90%	70% after deductible	80% after deductible	70% after deductible	80%	80%	90% after deductible	70% after deductible	50%	50%	80% after deductible	70% after deductible
Transplant Evaluation	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Other Organ and Tissue Transplants												
Bone Marrow Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Heart Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Heart and Lung Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered

BENEFIT SUMMARY/COMPARISON

This summary/comparison is intended to provide a condensed explanation of plan benefits.
Certain limitations, restrictions and exclusions may apply

Plan Design #	Active Plan Design #1		Active Plan Design #2		Active Plan Design #3		Active Plan Design #4		Active Plan Design #5		Retiree Plan Design #1	
Lifetime Maximum	Unlimited		$1,000,000 / $10,000 annual renewal		Unlimited		$2,000,000 / $10,000 annual renewal		$1,000,000 / $10,000 annual renewal		Unlimited	
Annual Deductible	$100 per person / $300 per family		$100 per person / $300 per family		None		$1,500 single / $3,000 per family		None		$100 per person / $300 per family	
Hospital Deductible	None		None		None		None		None		None	
Annual Copayment Maximum	$2,000 per person / $6,000 per family		$2,500 per person / $7,500 per family		$2,500 per person / $7,500 per family		$4,000 single / $8,000 per family		$10,000 per person		$2,500 per person / $7,500 per family	
Liver Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Lung Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Pancreas Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Simultaneous Kidney/Pancreas Transplant	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered
Small Bowel and Multivisceral Transplants	100%	Not Covered	100%	Not Covered	100%	100%	100% after deductible	Not Covered	100%	Not Covered	100%	Not Covered

NOTES

[1]: Immunizations for Hepatits-B are only covered for high risk conditions.

[2]: Physical and Occupational Therapy visits are determined based on the condition being treated. Once the limit has been reached, additional services will be denied.

[3] [4]: Physical and Occupational Therapy visits are determined based on the condition being treated. Once the limit has been reached, additional visits may be provided with prior approval.

[4]: Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year.

[5]: You must receive services from a provider that is an approved Blue Distinction Center for Transplants or is under contract with us for the specific type of transplant you will receive for these benefits to apply.

APPENDIX N

	Plan Design #6*	Plan Design #7*	Plan Design #8*
Deductible:	$850 in-network $1,700 out-of-network	$650 in-network $1,300 out-of-network	$450 in-network $900 out-of-network
Co-insurance:	75% in-network 50% out-of-network	80% in-network 70% out-of-network	85% in-network 70% out-of-network
Copay:	$20 on well care visits, immunizations	$20 on well care visits, immunizations	$20 on well care visits, immunizations
Out of Pocket Maximum:	$4,000 per person $12,000 per family	$3,000 per person $9,000 per family	$2,500 per person $7,500 per family
Lifetime Maximum:	None	None	None

***Please apply these following changes to Plan Design #1**

Appendix O
Ascend Specialty Pharmacy – Exclusive Provider

APPENDIX O
Speciality Drug List Master November 2007
(Ascend Exclusive)

Ascend SpecialtyRx
Simplifying Care. Achieving Outcomes.

HAWAII EUTF ACTIVES
SPECIALTY PHARMACY DRUG LIST

April 2009

ASCEND EXCLUSIVE

DISEASE	BRAND NAME	GENERIC NAME	ROUTE	JCODE	GPI-14
CROHN'S					
	Humira	Adalimumab	SQ	J0135	66270015006420
	Cimzia	Certolizumab Pegol	SQ	C9249	52505020106420
CYSTIC FIBROSIS					
	Pulmozyme	Deoxyribonuclease Alfa	INH	J7639	45304020002010
	TOBI	Tobramycin/NaCl 0.2%	INH	J7682	07000070002520
GAUCHER'S					
	Zavesca	Miglustat	PO	J3490	82700070000120
GROWTH HORMONE					
	Genotropin	Somatropin	SQ	J2941	30100020002184
	Humatrope	Somatropin	SQ	J2941	30100020002120
	Increlex	Mecasermin	SQ	J1270	30160045002020
	Norditropin	Somatropin	SQ	J2941	30100020002062
	Nutropin	Somatropin	SQ	J2941	30100020002121
	Omnitrope	Somatropin	SQ	J2941	30100020002123
	Saizen	Somatropin	SQ	J2941	30100020102120
	Somatuline	Lanreotide	SQ	J2941	30170050102040
	Somavert	Pegvisomant	SQ	J3490	30180060002120
	Tev-Tropin	Somatropin	SQ	J2941	30100020002121
	Zorbtive	Somatropin	SQ	J2941	30100020102132
HEPATITIS					
	Copegus	Ribavirin	PO	J3490	12353070000320
	Infergen	Interferon Alfacon-1	SQ	J9212	12353040102220
	Peg-Intron	Interferon Alfa 2B	SQ	J9215	12353060106430
	Pegasys	Peginterferon Alfa 2A	SQ	S0145	12353060052020
	Rebetol	Ribavirin	PO	J3490	12353070002020
	Ribasphere	Ribavirin	PO	J3490	12353070000120
	Ribapak	Ribavirin	PO	J3490	12353070000360
	Ribatab	Ribavirin	PO	J3490	12353070000320
	Ribavirin	Ribavirin	PO	J3490	12353070000120
HIV					
	Fuzeon	Enfuvirtide	SQ	J1324	12102530006420
	Serostim	Somatropin	SQ	J2941	30100020102125
INFERTILITY					
	Bravelle	Urofollitropin	SQ/IM	J3355	30062090102112
	Cetrotide	Cetrorelix	SQ	J3490	30090025106420
	Endometrin	Progesterone	TOP	J2675	55370060009910
	Follistim	Follitropin beta	SQ/IM	S0128	30062030102003
	Ganirelix	Ganirelix	SQ	S0132	30090040102020
	Gonal-F	Follitropin alpha	IM/SQ	S0126	30062030052115
	Luveris	Lutropin alpha	SQ/IM	J3490	30062045052150
	Menopur	Menotropins	SQ/IM	J0725	30062050002175

APPENDIX O
Speciality Drug List Master November 2007
(Ascend Exclusive)

Novarel	Gonadotropin,chorionic	IM	J0725	30062020002140
Ovidrel 250mcg PFS	Choriogonadotropin Alfa	SQ	J0725	30062022052120
Pregnyl	Chorionic Gonadotropin	SQ/IM	J0725	30062020002140
Progesterone	Progesterone	IM	J2675	26000040001705
Repronex	Menotropins	IM/SQ	S0122	30062050002155
MISCELLANEOUS				
Actimmune	Interferon gamma - 1b	SQ	J9216	21700060702020
Apokyn	Apomorphine	SQ	J0364	73203010102020
Arcalyst	Rilonacept	SQ	J3490	66450060002120
Cystadane	Betaine Anhydrous	PO	J3490	30904520002920
Exjade	Deferasirox	PO	J3490	93100025007320
H.P. Acthar Gel	repository corticotropin	IM	J0800	30300010004010
Kuvan	Sapropterin Dihydrochloride	PO	J3490	30908565107320
Mifeprex	Mifepristone	PO	S0190	30502060000320
Promacta	Eltrombopag	PO	J3490	82405030100320
Vivitrol	Naltrexone	IM	J2315	93400030001920
Xolair	Omalizumab	SQ	J2357	44603060002120
Xyrem	Sodium Oxybate	PO	J3490	62450060202020
MULTIPLE SCLEROSIS				
Avonex	Interferon Beta 1A	IM	J1825	62403060456420
Betaseron	Interferon Alpha 2b	SQ	J1830	62403060502120
Copaxone	Glatiramer Acetate	SQ	J1595	62400030106420
Rebif	Interferon, Beta-1a	SQ	J1825	62403060452020

APPENDIX O
Speciality Drug List Master November 2007
(Ascend Exclusive)

ONCOLOGY Oral/SQ (Self Administered)				
Afinitor	Everolimus	PO	J3490	21532530000330
Etopiside	Etoposide	PO	J8560	21500010000120
Gleevec	Imatinib Mesylate	PO	S0088	21534035100120
Intron-A	Interferon Alfa-2 B	SQ	J9214	21700060206450
Intron-A	Interferon Alfa-2 B	SQ	J9214	21700060206460
Matulane	Procarbazine	PO	S0182	21700050100105
Nexavar	Sorafenib	PO	J3490	21533060400320
Revlimid	Lenalidomide	PO	J3490	99394050000130
Roferon	Interferon Alfa	SQ	J9213	21700060106420
Sprycel	Dasatinib	PO	J8999	21534020000360
Sutent	Sunitinib	PO	J8999	21533070300120
Tarceva	Erlotinib	PO	J3290	21534025000360
Targretin	Bexarotene	TOP	J3490	90376220004020
Tasigna	Nilotinib	PO	J3490	21534060000120
Temodar	Temozolomide	PO	J0900	21104070000110
Thalomid	Thalidomide	PO	J3490	99392070000140
Tykerb	Lapatinib	PO	J3490	21534050100320
Viadur	Leuprolide	SQ	J9219	21405010106480
Vidaza	Azacitidine	SQ	J9025	21300003001920
Xeloda	Capecitabine	PO	J8521	21300005000350
Zoladex	Goserelin	SC	J9202	21405005102310
Zolinza	Vorinostat	PO	J3490	21531575000120
OSTEOPOROSIS				
Forteo	Teriparatide	SQ	J3110	30044070002020
PULMONARY HYPERTENSION				
Letairis	Ambrisentan	PO	J3490	40160007000320
Tracleer	Bosentan	PO	J3490	40160015000320
Ventavis	iloprost	INH	Q4080	40170060002020
PSORIASIS				
Amevive	Alefacept	IM	J0135	90250515002130
Enbrel	Etanercept	SQ	J1438	66290030006420
Humira	Adalimumab	SQ	J0135	66270015006420
RESPIRATORY SYNCYTIAL VIRUS				
Synagis	Palivizumab	IM	C9003	19502060002020
RHEUMATOID ARTHRITIS				
Enbrel	Etanercept	SQ	J1438	66290030006420
Humira	Adalimumab	SQ	J0135	66270015006420
Kineret	Anakinra	SQ	J3490	66260010002020
TRANSPLANT				
Cellcept	Mycophenolate Mof.	PO	J7517	99403030100120
Cyclosporine	Cyclosporine Modified	PO	J7515	99402020300120
Gengraf	Cyclosporine Modified	PO	J7502	99402020300150
Myfortic	Mycophenolate Acid	PO	J7518	99403030300630
Neoral	Cyclosporine Modified	PO	J7515	99402020300120
Prograf	Tacrolimus	PO	J7507	99404080000120
Rapamune	Sirolimus	PO	J7520	99404070000320
Sandimmune	Cyclosporine	PO	J7516	99402020002010

APPENDIX O
Speciality Drug List Master November 2007
(Physicians, Hospitals, Clinics Ascend)

Ascend SpecialtyRx
Simplifying Care. Achieving Outcomes.

April 2009

HAWAII EUTF ACTIVES SPECIALTY PHARMACY DRUG LIST

PHYSICIANS, HOSPITALS, CLINICS & ASCEND

DISEASE	BRAND NAME	GENERIC NAME	ROUTE	JCODE	GPI-14
CROHN'S					
	Remicade	Infliximab Recombinant	IV	J1745	52505040002120
	Tysabri	Natalizumab	IV	J2323	62405050001320
FABRY DISEASE					
	Fabrazyme	Agalsidase beta	IV	J0180	30903610102110
GAUCHER'S					
	Ceredase	Aglucerase	IV	J0205	82700020002020
	Cerezyme	Imiglucerase	IV	J1785	82700050002120
HEMOPHILIA					
	Advate	Factor 8	IV	J7190	85100010252120
	Alphanate	Factor 8	IV	J7190	85100030002180
	AlphaNine	Factor 9	IV	J7193	85100028002125
	Bebulin	Factor 9 - Complex Human	IV	J7194	85100030002150
	Benefix	Factor 9 - Recombinant	IV	J7193	85100028202120
	FEIBA VH	Anti-Inhibitor Coagulant Con	IV	J7198	85100020002100
	Helixate	Factor 8	IV	J7192	85100010206450
	Hemofil-M	Factor 8	IV	J7190	85100010002109
	Humate-P	Factor 8	IV	J7190	85100015102144
	Koate DVI	Factor 8	IV	J7190	85100010002110
	Kogenate-FS	Factor 8	IV	J7189	85100010206420
	Monarc-M	Factor 9	IV	J7190	85100010002147
	Monoclate-P	Factor 8	IV	J7190	85100010006410
	Mononine	Factor 9	IV	J7195	85100028002170
	NovoSeven	Factor 7a Recombinant	IV	J7189	85100026202130
	Profilnine	Factor 9	IV	J7195	85100030002180
	Proplex	Factor 9	IV	J7194	85100030002170
	Recombinate	Factor 8	IV	J7192	85100010202115
	Refacto	Factor 8	IV	J7192	85100010206450
	Xyntha	Factor 8	IV	J7192	85100010206420
IMMUNE SYSTEM / IVIG					
	Carimune	Immune Globulin	IV	J1562	19100020102112
	Flebogamma	Immune Globulin	IV	J1572	19100020102205
	Gammagard	Immune Globulin	IV	J1566/7	19100020102113
	Gamunex	Immune Globulin	IV	J1561	19100020102210
	Octagam	Immune Globulin	IV	J1568	19100020102205
	Panglobulin	Immune Globulin	IV	J1566/7	19100020102135
	Privigen	Immune Globulin	IV	J1459	19100020102010
	Vivaglobin	Immune Globulin	IV	J1566/7	19100020202020
MISCELLANEOUS					
	Elaprase	idursulfase	IV	J1743	30906850002020
	Macugen	Pegaptanib	IAV	J2503	86655050302020
	Nplate	Romiplostim	SQ	C9245	82405060002120
	Reclast	Zoledronic Acid	IV	J3488	30042090002020

APPENDIX O
Speciality Drug List Master November 2007
(Physicians, Hospitals, Clinics Ascend)

Visudyne	Verteporfin	IV	J3396	86700065002120
NEUROMUSCULAR				
Botox	Botulinum Toxin Type A	IM	J0585	74400020052120
Myobloc	Botulinum Toxin Type B	IM	J0587	74400020102020
ONCOLOGY IV/IM (Non-Self Administered)				
Abraxane	Paclitaxel	IV	J9264	21500012201920
Alferon	Interferon Alpha-N3	IM	J9215	21700060302020
Alimta	Pemetrexed	IV	J9305	21300053102120
Alkeran	Melphalan	IV	J9245	21101040102110
Aredia	Pamidronate	IV	J2430	30042060102120
Arranon	Nelarabine	IV	J9261	21300052002020
Avastin	Bevacizumab	IV	J9035	21335020002020
Bulsulfex	Busulfan	IV	J0594	21100010002020
Campath	Alemtuzumab	IV	J9010	21353010002040
Camptosar	Ironotecan	IV	J9206	21550040102020
Carboplatin	Carboplatin	IV	J9045	21100015002110
Cerubidine	Daunorubicin	IV	J9150	21200030102105
Cladribine	Cladribine	IV	J9065	21300007002010
Dacogen	Decitabine	IV	J0894	21300015002120
Daunorubicin	Daunorubicin	IV	J9150	21200030102210
Doxil	Doxirubicin HCl Lipo	IV	J9001	21200040402210
Eligard	Leuprolide	IM	J9217	21405010106415
Elitek	Rasburicase	IV	J2783	21764065002140
Ellence	Epirubicin	IV	J9178	21200042102020
Eloxatin	Oxaliplatin	IV	J9263	21100028002130
Epirubicin	Epirubicin	IV	J9178	21200042102020
Erbitux	Cetuximab	IV	J9055	21353025002020
Ethyol	Amifostine	IV	J0207	21758010102120

APPENDIX O
Speciality Drug List Master November 2007
(Physicians, Hospitals, Clinics Ascend)

Faslodex	Fulvestran	IM	J9395	21403530002020
Fludara	Fludarbine	IV	J9185	21300025102120
Fludarabine	Fludarbine	IV	J9185	21300025102120
Gemzar	gemcitabine	IV	J9201	21300034102140
Herceptin	Trastuzumab	IV	J9355	21353070002120
Hycamtin	Topotecan	IV	J9350	21550080102120
Ixempra	Ixabepilone	IV	J3490	21500011002120
Leustatun	Cladribine	IV	J9065	21300007002010
Leuprolide	Leuprolide Acetate	SQ	J9218	21405010106407
Lupron	Leuprolide Acetate Susp	IM	J9217	21405010106450
Mitoxantrone	Mitoxantrone	IV	J9293	21200055001310
Mylotarg	Gemtuzumab	IV	J9300	21355030202120
Navelbine	Vinorelbine	IV	J9390	21500050802020
Nipent	Pentostatin	IV	J9268	21700045002120
Novantrone	Mitoxantrone	IV	J9293	21200055001310
ONTAK	Denileukin	IV	J9160	21700024002020
Onxol	Paclitaxel	IV	J9264	21500012001320
Paclitaxel	Paclitaxel	IV	J9264	21500012001320
Paraplatin	Paraplatin	IV	J9045	21100015002110
Pentostatin	Pentostatin	IV	J9268	21700045002120
Proleukine	Interleukin-2	IV	J9015	21703020002120
Rituxan	Rituximab	IV	J9310	21353060001310
Taxol	Paclitaxel	IV	J9265	21500012001320
Taxotere	Docetaxel	IV	J9170	21500005001320
Torisel	Temsirolimus	IV	J9330	21532570002020
Treanda	Bendamustine	IV	J9033	21100009102120
Trelstar	Triptorelin	IM	J3315	21405050201920
Vectibix	Panitumumab	IV	J9303	21353050002020
Velcade	Bortezomib	IV	J9041	21536015002120
Zometa	Zoledronic Acid	IV	J3487	30042090001320

APPENDIX O
Speciality Drug List Master November 2007
(Physicians, Hospitals, Clinics Ascend)

ONCOLOGY ADJUNCT/ GROWTH FACTORS,ETC.					
	Aranesp	Darepoetin Alfo-Albumin	SQ	J0881/2	82401015112075
	Epogen	Epoetin Alpha	SQ	J0885/6	82401020002010
	Leukine	Sargramostim	SQ	J2820	82402050002030
	Mozobil	Plerixafor	SQ	J3490	82502060002020
	Neulasta	Pegfilgrastim	SQ	J2505	82401570002020
	Neumega	Interleukin II	SQ	J2355	82403060002120
	Neupogen	Filgrastim/G-CSF	SQ	J1440	82401520002020
	Octreotide	Octreotide Acetate	IV/SQ	J2353	30170070102030
	Procrit	Epoetin Alpha	SQ	J0885	82401020002010
	Sandostatin	Octreotide Acetate	IM	J2354	30170070106430
OSTEOARTHRITIS					
	Euflexxa	Hyaluronate Sod	IA	J7319	75800070102020
	Hyalgan	Hyaluronate Sod	IA	J7319	75800070102020
	Orthovisc	Hyaluronate Sod	IA	J7319	75800060002020
	Supartz 10mg/ml 25mg	Hyaluronate Sod	IA	J7319	75800070102020
	Synvisc	Hyaluronate Sod	IA	J7319	75800040002220
POMPE'S					
	Myozyme 50mg Vial	Alglucosidase	IV	J0220	30907715002120
PULMONARY DISORDERS					
	Aralast	Alpha1 - Proteinase Inhibit	IV	J0256	45100010102118
	Prolastin	Alpha1 - Proteinase Inhibit	IV	J0256	45100010101920
PULMONARY HYPERTENSION					
	Epoprostenol	Epoprostenol sodium	IV	J1325	40170040102110
	Remodulin	Treprostinil	IV	J3285	40170080102030
RHEUMATOID ARTHRITIS					
	Orencia	Abatacept	IV	J0129	66400010002020
	Remicade	Infliximab Recombinant	IV	J1745	52505040002120
	Rituxan	Rituximab	IV	J9310	21353060001310